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SURGERY

Ovarian Tumors:

Clinical and Physiologic Significance*

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It has been said that in the United States 600,000 people have malignant disease during a one-year period. Of these 600,000 people 200,000 die during the same period. These are rather startling figures. I cannot give you the exact percentage of malignant lesions that are confined to the female generative organs, but I can assure you that the incidence of malignant disease of the ovary, like that of the uterus, is extremely high. It is, therefore, important that physicians have a fairly clear picture of the clinical evidence of tumors of the adnexa, and that they try to evaluate what should be done.

The variation exhibited by neoplasms of the ovary is not duplicated in any organ of the body. This group is being continually expanded by the addition from time to time of what appear to be new entities. There are some tumors in this group which exert a physiologic influence on their host, which has led to exhaustive study of the hormonal content of these ovarian neoplasms. The best review of the subject that I have seen is that written by my colleague, Dr. Malcolm B. Dockerty, under the title, "Ovarian Neoplasms: A Collective Review of the Recent Literature," which appeared in the *International Abstract of Surgery*, September, 1941, volume 1, page 179.

In order to understand clearly the clinical, physiologic and surgical significance of neoplasms of the ovary, it is necessary that they be considered according to some scheme of classification. In such an outline, each neoplasm can then be properly classified. The classification which I shall follow, in part, is one inaugurated by Taylor of the Women's Hospital in New York City, which is based, for the most part, on the histologic characteristics. Taylor's scheme is simple, clear and concise, and is as follows:

- a. Functional cysts, which are corpus luteum and follicular cysts.
- b. Endometrial cysts.
- c. True neoplasms.
 1. Common epithelial neoplasms.
 2. Connective tissue tumors.
 3. Mixed tumors, which are the dermoids and the more complex teratomas.

4. Parenchymal tumors.
5. Tumors of uncertain status.
 - d. Metastatic tumors, such as the Krukenberg tumor.

It has been my impression that a great many young women are operated upon needlessly because somebody finds a cyst of the ovary. The majority of those cysts are so-called functional cysts, which perforate or rupture and disappear. That is what happens with practically all functional cysts, that is, follicular and corpus luteum cysts. Occasionally one will perforate and produce hemorrhagia, and this gives the picture of intra-abdominal hemorrhage.

Endometrial cysts are interesting. They are produced by endometrial lesions of the ovary with hemorrhage into, and complete destruction of, the ovary. An acute abdominal catastrophe is often produced by perforation of such cysts. Rarely does this type of cyst twist, because it is fixed under the broad ligament. I am under the impression that practically all so-called chocolate cysts are endometrial in origin. Proving this is a good bit like proving the presence of tuberculous organisms in the urine in a case in which tuberculosis of the urinary tract is suspected—if one hunts long enough, one is likely to find tubercle bacilli. Just so, endometrial tissue will be found in chocolate cysts if the search is continued long enough.

An endometrial cyst causes some rather interesting events because it produces almost complete destruction of the ovary. Thus, a young person will be gradually undergoing a slow menopause, so that when it comes time to sacrifice all of the ovarian tissue in order to relieve the individual of her pain, she suffers very little from the loss of ovarian substance, since practically all of it has been destroyed already.

Tubo-ovarian cysts are of interest. They may originate from tubal epithelium or they may be residua of pelvic inflammatory disease. As a matter of fact, one usually finds the end of the tube sealed over and if one looks the tube over very carefully, it can be quickly discovered that this is a tubo-ovarian and not just an ovarian cyst. Therefore, the chances are that it is benign and that the process which caused the cyst has completely disappeared. Perhaps if the patient is in the third decade of life, one can save a sufficient amount of ovarian tissue to maintain normal menstrual function. This is important in some of these cases.

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A tubo-ovarian cyst may be associated with complete destruction of the ovary and tube. Some tumors of this type are very difficult to remove surgically since they are so frequently attached under the broad ligament and to the ureter. It is in this type of case that injuries of the ureter are prone to occur during operation.

An abscess of an ovary or a tubo-ovarian abscess is a farther advanced lesion than a tubo-ovarian cyst. The ovarian wall around the abscess is often greatly thickened. Such an abscess will not break down as the result of any therapy that I know anything about. Fortunately, with the introduction of antibiotics, one sees relatively few conditions of this type. A lesion of this type requires complete excision; often it is necessary to remove the uterus because, otherwise the patient may have a recurrence of her trouble, probably a recurrence in the opposite ovary, so that subsequent surgical exploration is required.

One type of functional cyst is that associated with an endometrial implant on the ovary. This usually is a large chocolate cyst, which may cause complete destruction of the ovary. I can assure you that within this cyst there will be endometrium which is exactly like that in the uterus and which is undergoing all phases of menstruation. I am reasonably certain that the endometrial lesion works its way through the ovary and then, each month, there is a hemorrhage in the cyst which produces complete destruction.

A group of neoplasms about which there is a tremendous amount of misinformation or doubt consists of cystadenomas with papilloma which are benign. Many times these are thought to be malignant. These lesions are all surgical and they always contain clear fluid and are nonmucus-producing. They constitute about 15 per cent of the ovarian neoplasms. They are not observed prior to puberty; they are most common between the ages of 20 and 50. Sterility is frequent, occurring in about 25 per cent of cases. There is occasionally some ascites. The papillary projections within the cyst may have a confusing appearance. It should be remembered that whenever a lesion contains papillary projections it is usually malignant. Thus, papillomas of the bladder, colon, stomach, or other parts of the body are usually serious conditions. Nevertheless cystadenomas with papilloma are benign. Pure fibrous types of papilloma are characteristic of the benign lesions, whereas the malignant papilloma, while containing mucus, has a typical softness; these points are the basis for the gross differentiation between these lesions. Owing to the fact that a given lesion may be malignant, it is important that

it be removed without perforation; hence, differentiations cannot be made until after removal of the growth, when it may be opened and its contents examined.

Next I mention bilateral intracystic and extracystic serocystadenoma. Since opinion differs as to whether this type of lesion is benign or malignant, it probably is best, from the patient's standpoint to treat it as though it were of low-grade malignancy, even though one cannot always prove it so. The surgical results are very good.

Another interesting type of ovarian neoplasm, which is closely related to the others, is the large cystadenoma, which in one instance with which I am familiar weighed 63 pounds. The origin of such a neoplasm is probably from tubal epithelium. It never occurs before puberty, either. A cyst which appears before puberty is probably a functional cyst and is of very little significance. The operation in these cases, of course, consists of complete removal. If such a tumor is found in a woman of 30 to 40 years of age, a unilateral operation should be done on the basis that she probably would like to have more children. I shall not go into the histogenesis of these mucinous cysts except to say that they should be regarded as malignant.

Then there is the group of very serious tumors called "ovarian carcinomas." The dividing line between benign and malignant papillary growths of the ovary is by no means sharp. Consequently, the reports in the literature on incidence, symptomatology, treatment and prognosis are sometimes influenced by the author's conception of what actually constitutes a primary ovarian carcinoma. I think that it is extremely important for the surgeon to have a clear picture of not only the microscopic pathologic features but the gross pathologic characteristics as well. In one instance my colleagues and I observed an ovary in which endometrial tissue and cancer tissue lay adjacent to each other. This causes one to wonder why more carcinomas of the ovary are not considered on an endometrial basis, because the endometrium found in the ovary is of the same type as that found in the uterus, which does become malignant.

Bilateral extracystic papillary adenocarcinomas are encountered. Any lesion of this kind, which is on the outside of the ovaries and which one might consider to be a benign papilloma, will be found to be carcinoma if carefully examined. Carcinoma of the ovary in patients under 35 years of age is rare but it does occur sufficiently often to cause one to keep it in mind, and it usually will be of the extra-cystic papillary adenomatous type.

Non-Penetrating Injuries of the Abdomen*

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Non-penetrating injuries of the abdomen form that sizeable portion of abdominal surgery in which no missile or object has penetrated the parietes to inflict harm to the enclosed organs. Various authors also have referred to them as subcutaneous or subparietal injuries. They form a difficult but an ever-increasingly important group in surgical practice, not only because they seem to be increasing in frequency, but also classically they are associated with a high mortality, both pre- and postoperatively.

There are no reports in the contemporary literature which analyze a large series of cases. The majority of the writers dealing with abdominal injuries, probably under the war influence, have been concerned with penetrating injuries. Case reports on non-penetrating injuries are frequent and these suggest that if a large series were analyzed now lower rates than the 70-90% total mortality recorded in older reviews may be forthcoming.

This surgical condition or lesion is one that is frequent in peacetime, and differs little in nature or method of diagnosis from those met in war. In this breathing spell between our last and next conflict a better method for combating the injuries of the abdomen from all causes, including blast, may be worked out.

Incidents Producing Non-penetrating Injuries of the Abdomen

The increasing numbers and speed of motor cars and motor transport account for a large percentage of these patients. They occur also in train accidents, ship collisions, aeroplane crashes and industrial explosions, the severity of which may parallel those made by hostile hands. There is also the run-over victim, and the employee crushed in building, logging, or mining trades. It can happen with a fall on the feet or a kick by a cow. The opportunity to acquire the lesion appears to be increasing year by year.

Nature of the Lesion

This injury may be simple or complicated, single or multiple. It is simple when only abdominal organs or attachments are damaged. It is complicated by more evident severe damage to the head, chest, trunk or extremities. When there are seriously complicating injuries, it is only too true that the victim may not survive the transportation from the scene of the accident to the hospital. Some more do not survive the time necessary to take them from the admitting ward to the operating room. There are some, however, who might

conceivably survive both the abdominal and the complicating injury, if the abdominal one is recognized in time, and treatment completed. The kidney and bladder are extraperitoneal organs, and may complicate an intraperitoneal lesion. There are occasions when a lacerated kidney will suggest an acute intra-abdominal catastrophe, but certain findings will advise against laparotomy, or it may be impossible without laparotomy to rule out an intraperitoneal lesion as well. It is the surgeon's responsibility to miss no intra-abdominal lesion.

Simple lesions have been classified as involving (a) solid or (b) hollow viscera with their (c) mesenteric attachments. They may be single or multiple, and any combination of solid, hollow, or visceral attachment may be met. It goes almost without saying that the more multiple the lesions the higher the mortality. Porritt showed that when the small intestine was injured alone the mortality was 24%, but if combined with another visceral lesion it was 48%. If the colon alone was involved, the mortality was 11%, but combined with another lesion it was 69%.

Mechanism of the Injury

The exact mechanism by which a visceral lesion is produced has not been proved. A blow anywhere on the abdomen may rupture any viscus. Various explanations for the injuries in different organs, and the site of the lesion, have been advanced. It is said that the anterior aspect of the abdomen is less protected than the posterior, and that the thoracic cage, especially in the adult, protects the viscera beneath. Likewise the bony pelvis protects any organs within its confines. It is said that if the anterior wall is bruised or grazed that this is evidence that the viscera beneath are less likely to be injured. Pursuing this same concept, if the force of the external violence is such that it overcomes this protecting mechanism, then the viscera beneath may be injured by spicules of broken ribs or splintered pelvis, or they may be impaled on the transverse processes of the lumbar vertebrae or lacerated by compression against the prominent bodies of the dorso-lumbar spine.

A hollow viscus is less likely to be lacerated through all its coats if it is empty. If injured when full it is said to "burst." A blow delivered to a particular site will tend to injure the viscus beneath. Blows against the lower costal margin or epigastrium are more liable to lacerate the liver, spleen, pancreas, or the stomach. One delivered in the mid-abdomen is more likely to harm the small bowel or its mesentery. If delivered posteriorly it would conceivably rupture the kidney. There is yet, however, no infallible rule that will decide that one organ will be injured or that more than one organ will be involved if either or both the site and the force of the blow be known. It is known that a very low pressure exerted suddenly

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against the abdominal wall in under-water blasts will produce visceral lesions which demand surgical intervention for sure recovery. These lesions appear to occur where there is fluid and gas together. Commander Knight in the Royal Navy found that a blast pressure of six pounds to the square inch was sufficient to lift him off his feet and throw him across the deck. He did these tests with a protective suit, but even with it he could withstand no more than $7\frac{1}{2}$ pounds pressure. He described the sensation experienced as though his bladder had burst. Any pressure over $2\frac{1}{2}$ pounds to the square inch impaired efficiency. This is a long way from the 100 pounds to the square inch that many before had maintained was necessary to produce an intra-abdominal injury.

Diagnosis

This group of surgical emergencies has one of the most difficult problems. All authorities agree that delay in reaching a diagnosis is the greater factor for the high mortality. Dr. Roscoe Graham used to like to teach his house surgeon the minimal facts one must have to make the diagnosis of an acute abdomen. He laid a great stress on finding associated pain and tenderness. I think this is a good principle to keep in mind, but in this particular problem it is not sufficient. A purely parietal lesion will give associated pain and tenderness.

In the past such symptoms as pain, nausea and vomiting, inability to pass gas or void, and such signs as shock, tender and rigid abdominal wall, "silent abdomen," and the transmission of heart sounds to the lower abdominal quadrants have been spoken of as the classical symptoms and signs associated with an injury to an abdominal viscus or the presence of peritonitis. There has been a tendency to rely on some sign such as absence of peristalsis to signify absolute evidence of a perforated viscus or massive hemorrhage from a solid viscus, or a mesenteric vessel. The pain and associated tenderness in the abdomen may be due to a hematoma in the abdominal wall. The rigidity may be secondary to a chest injury. The silent abdomen is present for a time after spinal injuries which may have associated shock, or the sounds may be depressed but not absent for six hours after frank rupture of the small bowel.

The literature has numerous reports in which shock was not a prominent feature of an intra-abdominal lesion. It may be conspicuous by its absence. All of you have seen this aspect several times, and often it has lulled your suspicions of an acute abdomen.

What symptoms and signs then do make it imperative to operate on these patients? There is no one symptom or sign that can be called pathognomonic. One must have a complete picture of the patient. One must check against findings

as well as check for them. I have been impressed from the symptom point of view with the continued presence of pain; even if they are given sedatives they tend to manifest increasing restlessness. Their restlessness is mixed with an anxiety not usual to them. Their relatives may tell you he or she is getting worse although shock as gauged by the blood pressure cuff records no difference in the readings.

Many abdominal signs may be present, but if in addition to associated pain and tenderness there is absence of peristaltic sounds, the likelihood of an acute abdomen is much greater. Release tenderness is regarded by some as a brutal sign to elicit in an ill patient, but one might be forgiven its use in this instance when so much hangs on early diagnosis. Release tenderness, if present, is a sure sign of peritoneal irritation. If this sign is present with a rising pulse rate or persistently high pulse rate, then an acute abdomen is almost certainly present. One should have little doubt that a visceral lesion exists. If one is still in doubt one should operate.

Method of Approach

A routine approach to these cases makes for completeness of information and speed in examination. One should try to get as much information as possible about the accident, the nature of the agent, the force and suddenness of the blow. Where was the first pain? Did it involve the back or shoulder tip? Was it dull or sharp? One should not forget that the patient may have had previous chronic or acute disease. Have you been perfectly well up to now? A female may have a symptomless ovarian cyst, or be pregnant. A sudden mild blow to the epigastrium may rupture a gastric or duodenal ulcer, which has a gall bladder for its base. The patient is lucky if the gall bladder does not rupture too. One should, then, make a complete if rapid examination of the whole patient to exclude less evident injury to other parts of the body. The temperature, pulse, and respiration on admittance should be noted. One should observe if there are any grazed areas on the chest or abdomen. One should then exclude lesions which mimic the acute abdomen. There are the tabetic crisis and the dissecting abdominal aneurysm, both of which often present as external trauma. It takes only a moment to find the fixed pupil and the insensitive testis. One must note the obvious evidence of umbilical or groin hernia. It has been pointed out that rupture of the bowel is more likely to occur in their presence, especially if they are large.

The presence and site of associated pain and tenderness is confirmed. The extent of tenderness and rigidity is carefully observed. The presence or absence of liver dullness, peristalsis, shifting dullness or the presence of masses is noted. A

mass in the left upper quadrant may be a chronic spleen. Rectal or vaginal examination, or both, are always done. A large retroperitoneal hematoma from bladder to kidney may not be discovered except in this way. It is held by some that this occurs only in retroperitoneal lesions. The urine must be examined both macroscopically and microscopically. One should not hesitate to pass a catheter. The hemoglobin, white blood cell count and hematocrit should be done for a basis of operation, and at the same time the patient should be typed for transfusion. A high white blood cell count may indicate extensive soiling of the peritoneal surfaces. A flat plate of the abdomen should always be taken as the presence of free air may clinch a doubtful diagnosis.

The blood pressure should be taken on admittance, as it constitutes the best index one has for shock, and its variation helps to tell how therapy is progressing.

Treatment

There are three groups of patients from the treatment point of view in non-penetrating injuries of the abdomen.

(1) Those whom anti-shock treatment avails nothing, and they die quickly.

(2) Those who respond to anti-shock measures or remain stationary, and are operated on.

(3) Those in whom there is a delay in the period between the injury and the appearance of the signs of an acute abdomen.

The first and third are quickly disposed of. The one dies before operative procedures can be undertaken. The other should not be discharged from hospital, as long as he or she has abdominal pain or tenderness. Nearly all of us have seen the delayed rupture of the subcapsular hematoma in the liver, and the lacerated spleen. You have also seen the incompletely lacerated bowel burst or blow up as an acute intestinal obstruction.

For the other and vastly greater group, an admittance record should be made immediately for comparison at $\frac{1}{2}$ to 1 hour intervals. An abdominal injury deserves just as frequent observation as a head injury.

While this is being done, the patient is transfused with plasma or blood, as either shock or operation is anticipated. I believe if a shocked patient has not responded in four hours to vigorous anti-shock measures he will not in the next four. The higher mortality associated with the next four hours precludes the delay. Lockwood found that the mortality increased 15% with each succeeding four hours. I have not been sorry for operating on patients who could not be resuscitated. If the shock is due to continued bleeding from a definite source the patient will live. If the shock is due to massive loss of blood and plasma into multiple

areas, or a hemorrhage into the adrenals the patient will die with or without operation.

I also believe that gastric suction by a nasogastric tube should be started on the ward or admitting room. Cases have been reported where the tamponade action of the dilated stomach has a beneficial effect on the perigastric bleeding area, but the dangers of aspirated vomitus and the additional strain of vomiting constitute a greater hazard to the patient.

Unless there is some finding pointing to a definite location, the right paramedian incision centred on the umbilicus is the most useful. If rupture of the liver, pancreas, or spleen is very strongly suspected, a transverse incision serves well in people with a wide subcostal angle.

One should have a systematic method for examination of the abdominal cavity. The order of frequency of viscera involved can be recalled, namely liver, spleen, kidneys, intestines, stomach, bladder and pancreas. The source of hemorrhage should be sought first, should it be liver, spleen, or mesenteric vessels. Free portions of liver are removed. Mortality is lowest with suturing. It is higher if packing has to be used. The omentum is used by some surgeons for packing the deep lacerations. It is usually wiser to remove the spleen, although a minor laceration may be sutured. The pancreas may be sutured also. Good results follow and here one should be sure that the splenic vein is not bleeding. One must ascertain there is no rupture of stomach into the lesser sac, and no tear of the duodenum retroperitoneally. Exclusively retroperitoneal tears of the colon or small bowel must be very rare. Lacerations of the small bowel should be closed. Resection of an area does increase the mortality. It may be inevitable if wide portions of the mesentery are interrupted. There is a definite place for exteriorization of the open colon. In some sites one may have to do a simple closure with a proximal colostomy. The presence of infection argues for suprapubic drainage of the torn bladder.

Summary

This has necessarily been a synthesis of what I have been taught, read and that which I have tried and found good.

I have outlined the agents, nature, and mechanism of non-penetrating abdominal lesions. A method of approach for diagnosis has been advanced. It is stressed that early operation immediately on early diagnosis is most important to reduce mortality. Sometimes one must operate on the "shocked" patient.

No mention has been made of anaesthesia or the many postoperative complications which may

follow these injuries such as burst abdomen, infected abdominal wall, subphrenic abscess, bowel fistula, bowel obstruction, thrombosis and embolism. These do appear to occur less frequently now, and it may be due partly to the exhibition of antibiotics which lessen the complications of

many procedures in surgery.

In closing, I would stress again, as Ogilvie has remarked in regard to another condition that there is more joy in heaven over one live negative laparotomy than over ninety and nine positive ones who had it too late.

CASE REPORT

Strangulated Meckel's Diverticulum in Congenital Right Inguinal Hernia with an Undescended Ectopic Testicle

Jacob Hollenberg, M.D.

The first two cases of a Meckel's diverticulum in an inguinal hernia were reported by Littre in 1700. This is of interest because it was not until approximately a century later that Meckel described the embryological significance of the diverticulum named after him.

Other cases reported were by Mery in 1700, Walther in 1778, Boyer in 1882 and Malgaigne in 1840.

In 1923 Ludbrock described a strangulated Meckel's diverticulum in a femoral hernia as did Littler in 1924 and Harrington in 1926. Wiecks and Pflueger reported an additional case of a strangulated Meckel's diverticulum in a left inguinal hernia in 1933.

In 1923 Watson collected 147 cases, which to that date was the most comprehensive collection.

Meckel's Diverticulum. A Meckel's diverticulum is the remnant of the vitello-intestinal duct which normally becomes obliterated completely in the seventh intra-uterine month.

McGregor states that Meckel's diverticulum occurs in about 2% of all individuals coming to post mortem: the incidence in those undergoing laparotomy is approximately 0.5%.

The diverticulum arises from the ileum usually two feet from the ileocecal junction, and is about two to three inches long. It may, however, occur on any part of the mid-gut. It usually arises from the anti-mesenteric border of the small bowel and may or may not have its own mesentery, the blood supply being derived from the superior mesenteric artery.

The pathology commonly associated with a Meckel's diverticulum is closely allied to that of:

- (1) Vermiform appendix.
- (2) Gastric ulcer with its possible complications of:

- (a) Severe hemorrhage from erosion of a vessel.
 - (b) Perforation with subsequent peritonitis.
- Formation of a gastric ulcer in a Meckel's diver-

ticulum is explained by the occurrence of ectopic gastric mucosa in the diverticulum.

Other pathology commonly associated with a Meckel's diverticulum is:

- (1) Intestinal obstruction.
- (2) Intussusception.
- (3) Tumor formation.

Undescended Testicle. The testicle develops between the tenth and twelfth dorsal segments of the embryo deriving its blood, lymphatic and nerve supply from the region of these segments.

The testicle is developed on the inner aspect of the wolffian body from the germinal ridge, being covered by germinal epithelium derived from the epithelial layer of the peritoneum. The epididymus originates from the wolffian body and the vas deferens from the wolffian duct.

The descent of the testicle is accompanied by a peritoneal pouch—the processus vaginalis—which normally becomes obliterated soon after birth at two points.

- (1) The internal abdominal ring.
- (2) Just above the testicle—the obliterated portion between these two points is called the funicular process and the portion of the peritoneum about the testicle is called the tunica vaginalis.

The chronological order of testicular descent is as follows:

- (1) Third intra uterine month—loin to iliac fossa.
 - (2) 4-7th intra uterine months. Iliac fossa to abdominal inguinal ring.
 - (3) 8th intra uterine months internal to external inguinal ring.
 - (4) 9th intra uterine months to first postnatal months—external inguinal ring to base of scrotum.
- The mechanism of descent is entirely conjectural.

Abnormalities that therefore may result from faulty descent are:

- (1) Undescended testicle.
- (2) Ectopia testis.
- (3) Indirect inguinal (congenital) hernia.
- (4) Hydrocele, (a) Encysted, (b) Testicular.

Of the above abnormalities ectopia testis is the one to draw our attention in this case. By ectopia testis one implies that the testicle has deviated from its normal line of descent. The common sites of ectopia are as follows:

(1) Superficial inguinal ectopia. The testicles lying between the external inguinal ring and the anterior superior spine, superficial to the obliquus externus abdominis (external oblique abdominis.)

(2) Pubo-penile ectopia. The testicle resting at the root of the penis anterior to the pubis.

(3) Perineal ectopia. The testicle occupying the position anterior and lateral to the anus in the superficial perineal pouch.

(4) Femoral ectopia. The testicle descends to the anterior aspect of the thigh in the region of the fossa ovalis.

A point of interest with ectopia testis is that it is almost always associated with a complete congenital indirect inguinal hernia.

Case Report

Mr. J. K., aged 20, was admitted to hospital on October 21st, 1945.

Entrance complaints: Large painful lump in right groin for past two days. This patient had undescended testicles and has been able to feel both testicles in his respective groins for as long as he could recall. Occasionally, especially after drinking beer, a small lump would appear in the right inguinal region about the size of a walnut. This he could easily reduce. Two days prior to admission the patient was alarmed to find a very large lump in the right groin which he could not reduce. There was no pain but the following afternoon the patient went to bed as the lump was still there and was becoming tender to touch. The swelling in groin remained in the same condition until admission to hospital in the afternoon. The previous afternoon the patient lost his appetite but did not vomit. His bowels moved freely and on the morning of admission he was able to eat two oranges for breakfast but nothing else the remainder of the day. The tenderness became more severe.

Examination. This revealed a moderately firm, oval tender tumor in the right inguinal region 15 cm. wide and 2 cm. high, extending from 2.5 cm. medial to anterior superior spine of ileum to pubic tubercle.

Tentative Diagnosis. Strangulated right interstitial hernia, contents probably being omentum.

Operative Procedure. At operation, a classical right herniotomy incision was made, a large bluish discolored sac was exposed. This was opened and about 50 cc. blood tinged fluid escaped. The sac was complete from testicle, which occupied the superficial inguinal ectopia position, to external inguinal ring.

The contents of the sac was a long distended piece of bowel (size of a large distended vermiform appendix) which was at first thought to be an appendix, but which later on mobilization proved to be a Meckel's diverticulum.

The afferent and efferent loops of small bowel were delivered, the Meckel's diverticulum was resected aseptically between clamps. The testicle and cord were freed from the ectopic position and the sac was resected from just above the testicle to the internal inguinal ring. The inguinal hernia was repaired by bringing the conjoined tendon and external oblique down to the inguinal ligament, thus obliterating the external inguinal ring. That portion of the peritoneum left about the testicle was inverted about the testicle—(Bottle operation). The testicle was then brought down into the scrotal sac and forced through a small slit in the median septum of the scrotum so that the testicle occupied the opposite scrotal pouch to which it would occupy under normal descent. This procedure has been described by Ombredon and has proven to be very successful in our hands. It obviates a two stage operation for undescended testicle. All repair was done with No. 1 chromic catgut and skin incision was closed with silk worm gut.

Summary of operative procedures:

- (1) Resection of Meckel's diverticulum.
- (2) Repair of right inguinal hernia.
- (3) Bottle operation for right hydrocele.
- (4) Ombredon operation for right undescended testicle.

Pathological Report. Meckel's diverticulum with hernial sac and hydrocele. Specimen consists of a Meckel's diverticulum measuring 8.5 x 3 x 3 cm. Serosal surface is covered by thin fibrous exudate and the wall is reddened and hemorrhagic. On incision through the wall it is found to consist of an elongated tube measuring 6 x 3 cms. The distal end is completely occluded. 2.5 cms. from the proximal line of excision is a diaphragm, completely occluding the lumen except for a small central perforation which measures 1 to 2 mm. in diameter. The distal closed portion is filled with yellowish mucoid material. The lining of this portion is roughened and congested; the wall is thinned measuring 2 to 4 mms. in thickness. The distal portion of the diverticulum presents no gross abnormalities. The lumen is lined by normal appearing mucosa, as is the proximal side of the diaphragm.

Micro and Diagnosis. Acute inflammation of a Meckel's diverticulum. Also included are 4 strips of flat membranous tissue bluish white in color, one surface of which is smooth and shiny. They total 8 x 6 cms., no sections.

Progress. The patient was up and about on the third post-operative day and was discharged cured from hospital on November 2nd, 1945, a total of twelve hospital days.

Summary

- (1) A case is presented with the following congenital abnormalities:

- (a) Strangulated Meckel's diverticulum.
- (b) Complete right indirect inguinal hernia.
- (c) Ectopia testis of the superficial inguinal variety.
- (2) Descriptive surgical repair of the above defects.

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CASE HISTORIES—SURGICAL

Uterine Fibroids; Endocervicitis Total Hysterectomy

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This is the tenth of a series of Case Histories which will appear in the Review each month. The purpose of these publications is not to present rare or unusual cases but rather to consider the routine management of common surgical cases.

Case No. 47-10,236. Mrs. G. McP., St. Boniface Hospital. Color, white. Age, 49 years. Date of admission, July 28, 1947. Date of operation, July 30, 1947. Date of discharge, August 8, 1947.

Complaint on Admission

1. Hot flushes, 2-3 years. 2. Prolonged vaginal bleeding with menses, 1 year. 3. Bearing down discomfort, 6 months. 4. Progressive tiredness and exhaustion, 6 months. 5. Boring pain in right side during menses, 3 months.

Present Illness

For past 2-3 years patient has been having hot flushes coming on at intervals and she interpreted this as the "change of life." In July, 1946, she had her last normal menstrual period, which is usually a 22-day cycle with a 5-day flow, usually controlled by 12 sanitary pads throughout the period. There was never dysmenorrhoea or clots. In August, 1946, she had passed an interval of 76 weeks; when flow started it was profuse, with clots associated with a boring supra-pubic pain and radiating to the right lower quadrant. Since then the cycle varied in length of time from 4 to 5 to 6 weeks and she was no longer sure of the date of onset of the menses. The flow would last longer each month. During the last few months it would last 10-12 days, very profuse, numerous clots, and occasionally a foul odor. She uses 2-3 dozen pads. Hot water bottle gives relief but increases the flow. There has been no intermenstrual spotting or bleeding at any time.

On July 1, 1947, patient began to flow again, very heavy, with numerous clots lasting 3 days and then gradually decreased until July 7 when it became watery with pinkish tinge and foul discharge. On July 15, flow came on again and she

has been bleeding off and on especially when up and about. There was some rectal discomfort. Alarmed at the continuous bleeding, she came in for consultation.

Inventory by Systems

Eyes—Vision good. Wears glasses for reading.

Ears—Hearing good. No tinnitus or vertigo.

Nose—No epistaxis.

Respiratory—Does not get colds. No cough. No expectoration. No haemoptysis.

Cardio-vascular—Frequent attacks of palpitation. Dyspnoea on walking upstairs. No anginal attacks at any time. No dependent oedema.

Gastro-intestinal—Appetite good. Bowels becoming more constipated within past year and uses Epsom Salts 3 times a week. Intolerance to fatty foods, cabbage and pickles—cause flatulence and gastric distress. No epigastric pain. Occasional pain in rectum on defaecation. No melaena. No diarrhoea. No nausea or vomiting. No history of Gall Bladder colic or jaundice.

Genito-urinary—No frequency or nocturia. No haematuria. Urinary discomfort in form of supra-pubic pain and urgency during menses. Occasional incontinence and burning sensation on voiding. Has had albuminuria during pregnancy, also oedema of hands and feet.

Nervous System—Occasional throbbing headaches especially after a hard day's work or when down town shopping. No amnesia. No paralysis. Sleeps well. High strung and inclined to be irritable.

Metabolic—No loss of weight. No pyrexia. Fatigues easily.

Menstrual—Menarche at 10½ years. Menses always regular—interval 22 days; duration 5 days. No dysmenorrhoea or intermenstrual bleeding. No pruritus.

Obstetrical—Para iii; Gravida Vii. 1925—miscarriage at 8 months. 1926—one living child born at 8 months, by induced labor. Very difficult. Forceps delivery. 1928-1932—3 miscarriages at 2 and 3 months each. Induced on account of hypertension. 1933 and 1935—2 normal childbirths.

Family History

Father—Died, Cerebral Haemorrhage, age 84 years.

Mother—Died, Coronary Thrombosis, age 80 years.

Three children—Alive and well.

Husband—Alive and well.

Married 27 years.

Past History

Usual childhood diseases. Treated for toxæmia of pregnancy, 1928-1932. Treated for gall bladder trouble on account of intolerance to fatty foods, 1943, treated for essential hypertension. No operations. No accidents.

Physical Examination

Thin, frail little woman, with flushed face, rather shy and restless. Weight, 119 pounds. Very co-operative in giving history.

Head and Neck:

Cranial Nerves—Intact. No evidence of palsy.

Eyes—Lids, no drooping, normal excursions.

Conjunctivæ—no hæmorrhages. Pupils normal in size; react to light and accommodation. Fundi, mild narrowing of arterioles. No retinitis. No oedema of disks. No hæmorrhages.

Nose—Normal. No obstruction.

Tongue—Moist. No coating.

Teeth—Dentures.

Tonsils—Small and buried.

Neck—Thyroid not palpable. No adenopathy. Veins in right side of neck engorged with fairly marked venous pulsation.

Face—Somewhat flushed.

Chest:

Heart—Moderately enlarged. Apex beat 4 inches from midline at 6th rib. Heart sounds regular, very forceful. Beats 72 per minute. Occasional extra systole. Harsh systolic murmur radiating from mitral A.V. to aortic area. A₂ louder than P₂. Blood pressure 210/120.

Lungs—Thoracic cage normal contour. Movements equal and symmetrical. No dilated veins. Tactile fremitus good. No dullness on percussion. Breath sounds normal. No adventitious sounds.

Mammæ—Small, full breasts. No palpable masses. No mastitis. Nipple and areola normal.

Abdomen—Flat scaphoid abdomen. No dilated veins or scars. Abdominal reflexes: right ++, left ++. No apparent swelling. No distension. Soft. No tenderness. No rigidity. Liver and spleen not palpable.

Vaginal Examination—No varicosities or pruritus vulvæ. Introitus moderately lax with scarring in perineum. Cystocele grade ii on straining. Rectocele mild. Cervix large, lacerated, and with some central erosion and studded with nabothian cysts. Discharging a bloody brownish discharge. Uterus about size of 2 months pregnancy, freely movable. Uterus feels asymmetrical with hard rounded projection to right of the fundus and merging with it. Ovaries not palpable.

Rectal Examination—Small mixed hæmorrhoids. Some papillitis and cryptitis. No masses felt. Uterus and cervix easily palpated via rectal exam.

Spine—Normal curvatures. Free movements. No tenderness on percussion.

Extremities:

Upper—No wasting. Hands feel very warm and appear reddish. No deformities. No clubbing of fingers. No disturbances of sensation.

Reflexes:	Right	Left
Biceps	++	++
Triceps	++	++
Supinator	+	+

Lower—No deformities. No wasting. Moderate varicosities of left leg with incompetent saphenous veins. No oedema of ankles. No ulceration. Pulsations in dorsalis pedis and posterior tibial forceful. Vibration sense normal.

Reflexes:	Right	Left
Knee	++	++
Ankle	++	++
Plantar	V	V

Clinical Laboratory Findings

Urinalysis—July 29, 1947. Color, straw, turbid. Reaction, acid. Specific gravity, 1.029. Albumin, trace or + (.5 gms.) per litre of urine. Sugar, 0. Micro, 20-25 pus cells per h.p.f. 6-8 red cells per h.p.f. No casts.

Blood count—July 29, 1947. Red cells, 4,450,000. Hemoglobin, 92%. White blood cells, 5,200. Differential: Polymorphonuclear Neutrophils, 82%. Small and large Lymphocytes, 18%.

Blood Wassermann—Negative.

Mosenthal	Quantity	Specific Gravity
9 a.m.	180 cc.	1.022
11 a.m.	90 cc.	1.020
1 p.m.	100 cc.	1.013
3 p.m.	120 cc.	1.017
5 p.m.	126 cc.	1.020
7 p.m.	150 cc.	1.017
Night	350 cc.	1.024
Total quantity	1,116 cc.	
Total solids	59.37 gms.	

Blood Urea Nitrogen—13 mgms. per 100 cc. of blood.

Electrocardiogram—Inverted T-wave in lead i. Left axis deviation.

Sedimentation Rate—13 mm. in 1 hour (Wester-green).

X-ray of Chest—Diaphragms are normal. There is slight enlargement of the cardiac shadow. Lung fields are clear.

K.U.B.—Kidney and psoas shadows appear normal. No shadows are seen to suggest calculi.

Biopsy of Cervix—Chronic endocervicitis. No evidence of malignancy.

Diagnostic Curettage—Benign endometrium in follicular phase.

Pre-operative Diagnosis

Intra-uterine fibroid.

Essential hypertension.

Indications for Operation

Progressive menorrhagia, with absence of intermenstrual bleeding, and palpation of a hard, smooth tumor in uterus, with negative biopsy findings, make hysterectomy imperative. Total hysterectomy was the operation of choice on account of a lacerated cervix with erosion. Essential hypertension was not a contra-indication to operation.

Pre-Operative Care

Full permission for hysterectomy signed by husband and wife. Was admitted for 2 days pre-operatively. Fluids and light diet the day before. Enema at bedtime and in the morning pre-operatively. Vaginal preparation. Vagina scrubbed daily with soap and water. Two douches daily, 1:5000 bichloride of mercury solution. Painting of vagina with mercurochrome 5% after each douche. Operative preparation, shave. Scrub with soap and water. Vagina painted with 1:5000 bichloride solution. Cleaned with ether. Painted with merthiolate over perineum and entire abdomen. Catheterized. Re-examined patient under anaesthesia. Small pillow placed under the back—Trendelenberg position. The patient was in a good state of hydration and nutrition, so that she did not require any special care in that direction. Matched for blood transfusion.

Detailed Description of Operative Technique and Operative Findings

Position—Supine.

Incision—Median infra-umbilical incision about 6 inches long, extending upwards to the left of the umbilicus. Skin, superficial fascia and linea alba incised in same line. Peritoneum incised lateral to atrophied urachus. Skin towels.

Exploration—Stomach palpated for ulcer or growth—negative. Since the patient was treated for gall bladder trouble, the gall bladder was palpated but no evidence of stones or adhesions was found. Gall bladder emptied readily on compression.

Colon Palpated—Normal throughout. On account of essential hypertension, kidneys were palpated; normal in size and contour, and position.

Pelvis—Uterus was retroverted and a fibroid the size of an orange projected from the right lateral wall. Ovaries small, and tubes normal. Patient was now placed in Trendelenberg position. Large packs to wall off intestine; small pack in pelvic floor under uterus.

The uterus was now grasped with a curved Perry clamp, which was used for traction on the uterus. Two large clamps were next placed close to the uterus on the upper part of the broad ligament containing the fallopian tube, ovarian liga-

ment (containing the ovarian vessels) and the round ligament, and these structures were cut between the clamps, transfixed and tied with a figure of 8 suture-ligature so as to prevent slipping. A series of clamps were applied in pairs to the broad ligament alongside the uterus and the broad ligament divided between the clamps. The tissues in the clamps were transfixed and ligated with chromic catgut No. 1 suture-ligature. The uterus was then pulled over to the right and the structures on the left side divided in a similar manner. At the level of the uterine isthmus an incision convex upwards was made through the peritoneum on the anterior wall of the uterus and continued laterally on both sides to meet the incisions in the broad ligaments. This peritoneal leaf and the bladder was now stripped off the front of the uterus, supravaginal cervix, and upper part of the vagina with gauze dissection and the bladder was drawn towards the symphysis with a special retractor. A similar incision was made the posterior aspect of the uterus and the peritoneum reflected. Strong traction in an upward direction on the uterine seizing forceps was made and two heavy artery forceps were applied to the uterine vessels on each side at the level of the internal os in such a way as to grasp a portion of the cervix in the clamps. The vessels were cut between the clamps and doubly ligated with chromic catgut i. The uterus was forcibly pulled upwards and with a sharp knife an incision was made into the anterior vaginal wall just distal to its junction with the cervix, the knife angling downwards and backwards. The incision was enlarged transversely. The cervix was then seized with a volsellum and the rest of the vaginal wall circumcised. At the postero-lateral part of the incision on each side, the utero-sacral ligaments were clamped and transected. The uterus and cervix were placed in a specimen basin. The edges of the vaginal wall were grasped with Allis forceps, and painted with merthiolate. The bleeding points were transfixed and ligated. The cut edges of the vaginal vault were approximated with a continuous lock suture of chromic catgut No. 1. The utero-sacral stumps were tied together in the midline, so as to form a support for the vaginal vault. A chromic catgut No. 1 suture was then placed through the apex of the vaginal vault and the ligated stumps of the ovarian and round ligaments were approximated and tied into the apex of the vaginal vault with this suture. The anterior and posterior edges of the peritoneal leaflets were approximated by a continuous catgut stitch to cover all raw surfaces. The gauze packing in the Pouch of Douglas was removed and the field inspected for oozing. A long kinked appendix was removed en passant. The gauze packs were removed. Correct sponge count confirmed.

Closure of wound—the peritoneum was closed

with a continuous chromic catgut No. 1 suture. The fascia was closed with interrupted chromic catgut No. 1 sutures. The skin was approximated with interrupted silkworm gut sutures.

Anaesthetic

Pre-medication—Tuinal grs. iii at h.s. Morphine gr. 1/6 with atropine 1/150 one hour pre-operatively.

Condition of patient—Good. Temperature 98° F. Pulse, 68. Respiration, 18. Unfavorable features: Hypertension. Blood pressure, 210/120.

Agents—Pentothal, 7 cc. 2½%. Cyclopropane and nitrous oxide supplemented. Curare 3 cc.

Technique—Mask, closed, pharyngeal airway. Stimulants—None used.

Comments—No drains or packing. Haemorrhage minimal. Sponge count correct.

Post-operative Condition—Good.

Gross and Microscopic Description of Tissues

Removed

Tissue No. 2767-8—(Dr. Prendergast).

Subtotal Hysterectomy—Body of uterus is of large pear size, but contour asymmetrical; mucosa brownish and 2 mm. thick. Single fibroid present, of hen's egg size, partly intramural and submucous; easily half of it fills and distends canal.

Appendix (en passant)—Of normal caliber and appearance; no adhesions; lumen small and empty.

Micro—Uterine mucosa benign and in follicular phase. No malignant changes in fibroid.

Final Diagnosis

Submucous fibroid of the uterus.

Chronic endocervicitis.

Essential hypertension.

Progress Notes Including Post-operative Care During Stay in Hospital

July 31, 1947—Immediate post-operative condition of the patient was excellent. Temperature, 98° F. Pulse, 68. Respiration, 18. During the first two days her temperature reached 100° F. and the pulse varied between 72 and 90. Abdominal distension was completely absent. No vomiting. Catheterized OH viii for 2 days. Moved frequently from side to side the first day.

August 1, 1947—Up and around.

August 2, 1947—Olive oil retention enema given.

August 3, 1947—Mild cathartic at bedtime. No douches or irrigations given at any time.

August 7, 1947—Stitches removed.

August 8, 1947—Discharged from hospital.

Condition on Discharge

Patient felt exceptionally well.

Was walking about freely.

Absolutely no complaints.

Follow-up Notes Since Leaving Hospital

October 12, 1947—Office visit. No complaints. Pelvic examination: vaginal vault well suspended; no masses felt in the abdomen. Stilbesterol 1 mgm. at bedtime prescribed for hot flushes.

November 7, 1947—No complaints from the operation.

August 8, 1949—No complaints. Perineum and vaginal vault well suspended.

OBITUARY

Dr. G. Stuart Musgrove

It is hard to believe that our recent colleague, in the prime of manhood, is no longer with us. No details of the motor accident which cost him his life have come, the only message being a brief report by the British consul general at Basrah, Iraq.

The eldest son of the late Dr. W. W. Musgrove inherited his love of knowledge and of sport. In university circles he was known for his ability as a hockey defence player. Shortly after graduating in medicine he joined the R.A.M.C. and served for ten years, chiefly in India, as a specialist in surgery and later as officer commanding a military hospital.

Returning to Winnipeg in 1945 he began post-graduate work in the Winnipeg General Hospital,

then went to Belfast and London where he obtained the M.R.C.O.G. degree. Back in Winnipeg again he was associated with Dr. F. G. McGuinness and became a member of the Department of Obstetrics and Gynecology, Winnipeg General Hospital. With Dr. McGuinness he contributed to the C.M.A. Journal an account of the recent epidemic of puerperal mastitis.

Only about six months ago he accepted an offer from the Iraq government and was appointed specialist in Obstetrics and Gynecology at the Maude Memorial Hospital, Basrah.

He leaves behind him his wife and daughter, his mother and two brothers, Dr. J. Edward (Ted) of Albuquerque, New Mexico, and Ronald of Toronto, Canada.

MEDICINE

Multiple Sclerosis Studies in the United States and Canada*†

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The reported variations in distribution of multiple sclerosis suggest an association of disease prevalence with some factor related to geography or climate. Sällstrom¹⁰ in 1942 reported: "If one wants to make a short summary of what is known about the occurrence and distribution of multiple sclerosis, one can say that the disease is rather common both in Europe and North America. In both continents the northern part seems more affected. As Steiner¹¹ expressed it: "Multiple sclerosis is rare in Europe below 40 degrees north latitude (which passes through mid-Spain, southern Italy, and Greece), and in the U.S.A. below 30 degree north latitude (which passes through southern Texas and Louisiana and northern Florida). In some other parts of the world, such as Asia and North Africa, the disease is very rare."

The results of previous morbidity surveys 1. 2. 3. 5. 8. 10. 11 have generally indicated higher frequencies in regions away from the equator, but the surveys have not been conducted uniformly and their results have not been strictly comparable. The incommensurateness of these studies, which raises a question as to the validity of the reported uneven distribution, may be due to one or more of the following reasons:

1. A lack of uniformity in diagnostic criteria.
2. Variations in the method and completeness of case finding in the different investigations.
3. In developing rates, the failure to relate cases to the appropriate population.

Where there are differences in language, medical practice and terminology and hospitalization procedure, it is even more difficult to determine whether reported variations in multiple sclerosis prevalence based on studies conducted at different times by different investigators in various parts of the world are due to real differences in frequency or are due to variations in methods of study.

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†Abstracted from paper read at Meeting of the Manitoba Medical Association, Winnipeg, Manitoba, October 5, 1950.

If an unusual distribution could be confirmed by uniform surveys in selected areas of the United States and Canada, where medical facilities and practices are similar but where differences of climate and racial composition of the populations are marked, it might aid in clarifying the relationship of geographic, racial and climatic factors to the etiology and prognosis of the disorder.

This was recognized by the Medical Advisory Board of the National Multiple Sclerosis Society which several years ago endorsed the proposal for multiple sclerosis morbidity studies in Winnipeg, Manitoba, New Orleans, Louisiana, and other cities and for multiple sclerosis mortality studies in the United States and Canada.

In the morbidity surveys, the enumeration of recognized cases of multiple sclerosis and the charting of time relationships between possible predisposing factors and onset of symptoms is difficult because: 1. There is no specific diagnostic test or pathognomonic clinical finding which positively diagnoses multiple sclerosis or establishes the time of onset during life. 2. The chronicity of the disease and the failure of many patients to remain under medical observation, when no curative treatment can be offered, make it difficult to trace patients who have been ill for several years. 3. As treatment is often symptomatic, patients may be followed by general practitioners as well as specialists. 4. In the early stages, diagnosis may be difficult because of the vague symptoms or because other disorders of the central nervous system may have to be ruled out before the diagnosis can be seriously considered. 5. Spontaneous remissions which are seen in many cases of multiple sclerosis may last for months or years and frequently interfere with continuous observation of the patient by the physician. Because of such problems, it appeared necessary to search for case reports in all medical facilities for what might be considered a reasonable length of time. We could not search for cases too far back because of the limitation of our research facilities, but it was felt that where records were kept, as in hospitals, we would find reports on most living patients if a period of ten years were covered. As many physicians keep no records but rely on memory, it was felt that the request for case reports from physicians should extend back for no more than five years.

Description of Method of Study

Therefore all registered physicians in each city were queried and detailed reports were obtained from those who had had cases during the previous five years. The diagnostic files of all the hospitals, clinics and nursing homes were examined and case

records for the previous ten years were abstracted. We also obtained copies of death certificates for the preceding ten years in which multiple sclerosis was listed as the primary cause of death.

After assembling the detailed reports of suspected and diagnosed cases, duplications were omitted and each case followed through to the most recent source of medical observation. The latest diagnosis was determined and each case was classified as "probable," "doubtful" or "unlikely" on the basis of the most recent complete source of information.

Prevalence ratios were determined by relating the total number of "probable" patients living in New Orleans on December 1, 1948, and in Winnipeg on January 1, 1949, to the estimated population in the respective community.

The collection of reports began in New Orleans in December, 1948, and in Winnipeg in June, 1949, and was completed about a year later. During the last month of the survey period, each of the larger hospitals was rechecked for recently recorded cases and each survey report was re-examined to establish the latest diagnosis and status of each patient.

Of 239 case reports collected in Winnipeg, 168 (70%) were classified as "probable"; of 148 collected in New Orleans, 95 (64%) were so classified. The values of the epidemiological constants were determined only on the basis of "probable" cases which were those supported by an autopsy report or a physician's opinion as multiple sclerosis without any clear-cut contradictory evidence. Special inquiries indicated that 85% or more of a sample of the diagnosed cases of multiple sclerosis in each city were included in the "probable" case registry.

The population of metropolitan Winnipeg⁵, which is almost entirely white, was estimated as being 313,600 (153,100 males and 160,500 females) on June 1, 1946. The population of metropolitan New Orleans⁹, as estimated on April 1, 1947, was 601,500, of which 206,900 were white males; 227,900 were white females; 78,800 were colored males; and 87,900 were colored females.

All of Winnipeg's 168 "probable" reports were on white patients, and, of these, 132 (51 males and 81 females) were known to be alive and living in Winnipeg on January 1, 1949. The estimated prevalence ratios per 100,000 population for Winnipeg are, therefore, 33.3 for males, 50.5 for females, and 42.1 for the total population.

Of the 95 cases in the "probable" category in New Orleans, 71 (23 white males, 35 white females, 7 colored males, and 6 colored females) were known to be alive and living in New Orleans on December 1, 1948. The estimated prevalence ratios per 100,000 population in New Orleans were, therefore, 11.1 for white males, 15.4 for white females, 8.9 for colored males, 6.8 for colored females, and 11.8 for the total population. Because of the small

number of cases, the differences by sex and color in New Orleans cannot be considered as statistically significant. The prevalence based on reported diagnosed cases of multiple sclerosis in Winnipeg is, therefore, about 3.6 times that of New Orleans.

In addition to the intensive studies in Winnipeg and New Orleans, the frequency of multiple sclerosis over a wide area was assessed by reviewing the 1947 mortality studies for regions of the United States and for Canada. Limburg⁷ had studied the crude rates for the provinces in Canada and the states in the U.S., but in the present study adjustments for age and color differences in the populations were made. In addition, the death certificates listing "cerebral sclerosis" as a cause of death, which had originally been included in the multiple sclerosis category, were shown to be cerebral arteriosclerosis and were excluded. This resulted in an 18% reduction of the total mortality rate⁶.

The age adjusted rates for deaths from multiple sclerosis for the white population were then found to be as follows: 1.21 per 100,000 in Canada, 1.14 per 100,000 in the North Central states, 1.04 per 100,000 for the Northeastern states, 0.88 per 100,000 for the Western states (including the Northwestern and Southwestern states) and 0.46 per 100,000 for the Southern states.

Even with these adjustments and corrections, we still cannot be certain that the rate differences are real. It is conceivable that better recognition of the disease, better diagnostic facilities, and differences in the practice of seeking medical care in different regions might influence the reported number of deaths. It seemed worthwhile to study the geographic distribution of death rates for another relatively uncommon disease. Such action, it was hoped, might help to indicate whether differences in the availability and use of diagnostic facilities, or the completeness of mortality reporting, might have accounted for the marked differences in the geographic distribution of the deaths.

Ulett¹² had attempted, a few years before, to compare the geographical distribution of cases of Hodgkin's disease with those of multiple sclerosis, but unfortunately he had not been able to complete the project. For our study, we obtained the regional distribution of Hodgkin's disease death rates for 1947. These rates, adjusted for age, are 1.5 for Canada and 1.6 for the United States (north east 1.7, north central 1.5, south 1.4 and west 1.5). These are of only a slightly higher order of frequency than that reported for multiple sclerosis. Hodgkin's disease has about the same age distribution at time of death, and, in general, also requires fairly good diagnostic facilities for accurate diagnosis. There was no known reason to expect any measurable difference in the geographic dis-

tribution or in the degree of difficulty of diagnosis, though these were assumed prior to this portion of the study without actual figures. Hodgkin's disease was chosen for study as there was no other suitable non-infectious neurological disease or other condition which met as well the general requirements desired.

It is evident that the regional distribution of mortality from Hodgkin's disease shows no such difference as was seen for that of multiple sclerosis.

Thus, evidence was accumulated by local morbidity studies in two cities and by regional mortality studies to indicate that multiple sclerosis is more prevalent and is more frequently a cause of death in the Northern states and Canada than it is in the South.

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Penicillin Schedule for Syphilis*

A. Acceptable Penicillin Schedules for Syphilis

1. For Early, Latent and Benign Late

Total dosage 6 million units using Procaine Penicillin in Oil and 2% Aluminum Monostearate.

- (a) 600,000 units (2 cc.) daily, or
- (b) 600,000 units (2 cc.) three times per week or
- (c) 0.9 to 1.2 million units (3 to 4 cc.) two times per week.

2. For Neurosyphilis

600,000 units (2 cc. daily)

Total dosage 9 to 12 million units.

3. For Cardio-vascular

(a) With failing compensation, no antiluetic, only symptomatic treatment.

(b) Compensation regained or moderate cardiac involvement.

1. Bismuth and pot. iodide for two months.

2. Mapharsen 0.01 gm. increasing by 0.01 gm. with each injection, until moderate dosage attained (Maph. 0.03 gm.) after which eight injections given.

3. Penicillin may then be considered cautiously.

(c) Minimum to moderate cardio-vascular involvement, Penicillin may be tried from start in small dosage to test tolerance at several day intervals increasing to full dosage in about three to four weeks—then 300,000 units daily for fifteen days.

(d) Probably two or three courses are given in first twelve to eighteen months and then once annually. Penicillin is in experimental stages so

far as cardio-vascular lues is concerned.

4. Interstitial Keratitis

Schedule 1, and if no rapid response, add fever (typhoid vaccine, malaria or cabinet) arsenical and bismuth adjuvant therapy given in resistant cases.

5. For Syphilis in Pregnancy

(a) Preferably Procaine Penicillin G. in water 300,000 units daily for fifteen days.

(b) For ambulatory patients use Schedule 1 or 2, but aqueous preparation is possibly slightly superior.

6. For Infants

Procaine Penicillin G in water 75,000 to 100,000 units once daily for fifteen days.

7. For Late Congenital

Same as adults.

8. Adjuvant Therapy for Relapse, Resistance, Tertiary and Neuro

Adjuvant therapy with Mapharsen twice weekly and Bismuth Salicylate once weekly for ten weeks.

Malaria plus Penicillin is given in Neurosyphilis if response to Penicillin is unsatisfactory.

B. Re-Treatment Indicated In:

1. Relapse

(a) Clinical which is usually preceded by serologic relapse.

(b) Serologic.

1. Blood, with increasing titre following decline.

2. C.S.F. becomes abnormal—neuro-recurrence.

(c) One must not be misled by minor fluctuations in titre, which may be caused by day to day variations in laboratory performance, nor by temporary rise in titre due to some intercurrent disease.

*Summary presented at Winnipeg Medical Association Meeting, January 21st, 1950, by Dr. K. J. Backman, Director of Venereal Disease Control, Manitoba Department of Health and Public Welfare.

2. Sero-Resistance

Early syphilis:

(a) No appreciable decline in titre within six months (in pregnancy three months).

(b) Kahn Positive in 4 dils (16 Kahn units) or higher at end of one year.

Late syphilis: (Wassermann fast is the rule).

(a) Positive in high titre after six months.

(b) Marked sustained rise in titre from previous levels.

(c) Clinical relapse or progression.

(d) Positive in low titre is not an indication for re-treatment.

3. Neurosyphilis

(a) Clinical relapse or progression.

(b) C.S.F.

i. Relapse.

ii. If cells and protein do not return to normal.

iii. The presence of increasing neurological signs or psychosis or the occurrence of abnormal cells and protein in the spinal fluid are most important. A high titre Wassermann is suggestive of active disease but many of these patients are Wassermann fast. If after repeated examinations over 5 years there are no evidences of clinical or C.S.F. progression the process is probably inactive.

C. Post Treatment Followup:**Blood S.T.S. Quantitative Along With Physical Examinations**

Early syphilis:

1. Monthly till negative, in any event for six months.

2. Then at three-month intervals till end of two years.

3. Then twice a year till end of five years.

Late syphilis:

1. Every three months for one year.

2. Every six months for four years.

C.S.F. (Cells, Protein, Mastic and Wassermann)**1. Primary and Secondary**

i. In six months and in two years.

ii. Need not be repeated further unless clinical or blood serologic relapse.

ii. Immediately with any relapse.

2. Early Latent (Under 4 Years)

i. At once to rule out neurosyphilis.

ii. Immediately with any relapse.

iii. In two years.

3. Late

Immediately and if negative need not be repeated.

4. If C.S.F. Abnormal

i. Every six months post-treatment for two years.

ii. Then yearly for three years.

iii. Then only on clinical evidence of progression on relapse.

Report and Comments on the Red Cross Blood Bank, October, 1950

Name of Hospital	Elective and Urgent		Emergency	
	Issued	Used	Returned Unused	Bottles Used
Winnipeg General	728	409	319	218
St. Boniface	440½	228½	212	132
Misericordia	195	136	59	96
Deer Lodge	99	63	36	28
Grace	148	88	60	71
Victoria	73	59	14	42
St. Joseph's	35	25	10	18
Children's	34	25½	8½	27
Concordia	18	14	4	11
King George	2	2	1	1
Others	64	55	9	23
Totals	1836½	1105	731½	667

Comments

During October nineteen hospitals outside the city were supplied with blood or plasma. The position seems to have become stabilized somewhat. There is no gross alteration for the last month or two. I would like to repeat that the amount of blood issued is still out of all proportion to the amount of blood actually used and I would request that earnest efforts be made to rectify this situation.

Owing to further donor drives, coupled with very successful mobile clinics in the country, our reserves of plasma have now been lifted out of the doldrums, but even so, I shall not be happy until our reserves are at least double what they are today. The need for new blood donors is always with us and I would ask that every medical man continues and extends his activities on behalf of the community blood bank.

November, 1950.

Cecil Harris, B.Sc., M.D., M.R.C.P.,
Provincial Medical Director.

**Hospital Clinical Reports
Victoria Hospital**

A case of recurrent epistaxis in a hypertensive male, age 63, was presented by Dr. T. E. Beighton with discussion of etiology and therapy. Dr. P. Green dealt with the hematological aspects and prostatic carcinoma as a cause, while Dr. J. Newell spoke on local lesions causing nose bleed. It was stressed that epistaxis in the aged is almost always constitutional in origin.

Drs. J. E. Tisdale and D. Swartz spoke on geriatric complications (a) the cardio-vascular problem, (b) dehydration, and especially (c) urinary retention. Dr. Swartz stressed the importance of avoiding uremia by early recognition of retention and of slow decompression with an indwelling catheter if chronic retention is present.

T. E. Beighton, M.D.

Book Review

Medical Jurisprudence and Toxicology, by John Glaister, J.B., D.Sc., M.D., F.R.S.E. Ninth Edition with 234 illustrations, 88 in color. Published by Macmillan Company of Canada. Price \$6.75.

For nearly half a century Glaister's Medical Jurisprudence has been the standard work upon the subject in English. Last year it was awarded the Swiney prize as the best work on Medical Jurisprudence and now a new (9th) edition has been published. This edition has been enlarged, and revised, and many illustrations have been added. It is replete with case histories and is encyclopedic in its scope.

The Shortage of Medical Officers Canadian Armed Forces

The formation of the Special Force Brigade Group for Korea has involved a commitment for 25 additional medical officers. To date there have only been four volunteers. To fill in some of the gaps a number of active force medical officers have been seconded for duty with this force. This has left a hole in the already short staffed R.C.A.M.C. There is now an urgent need for physicians in military camps in Canada, either appointed to the army or employed on a locum tenens basis.

Present requirements for the Special Force are:

- 2 Graded Surgeons for F.S.T.
- 2 Graded Anaesthetists for F.S.T.
- 1 Medical Officer for F.T.T.
- 5 Medical Officers for F.D.S.
- 1 Major (experienced) for 25 Fd. Armb.
- 9 General duty Captains.

The Canadian Force being sent abroad is a volunteer force. They will likely be involved in active operations. It is considered that the medical profession of Canada has an implied responsibility in seeing that the Canadian troops in action have a satisfactory Medical Service. Have you thought of your individual responsibility in this connection? Further information may be secured from the Command Medical Office, Fort Osborne Barracks.

Clinical Luncheons

Time Table for Clinical Luncheons held during the Season in Greater Winnipeg Hospitals. The days in each month on which the luncheons are held are listed herewith. Visiting doctors are welcome.

- 1st Monday—Deer Lodge Hospital.
- 1st Tuesday—Municipal Hospital.
- 1st Thursday—Winnipeg General Hospital.
- 1st Friday—Children's Hospital.
- 2nd Tuesday—Misericordia Hospital.
- 2nd Thursday—St. Boniface Hospital.
- 2nd Friday—Victoria Hospital.
- 3rd Tuesday—Grace Hospital.
- 3rd Thursday—Winnipeg General Hospital.
- 4th Tuesday—St. Joseph's Hospital.
- 4th Thursday—St. Boniface Hospital.

University of Manitoba Medical College

Post Graduate Refresher Course

Attention all Physicians

An enlarged course of interest and value to all Physicians will be held March 26th to March 30th, inclusive.

Guest Speakers:

Dr. Ray Farquarson, Professor of Medicine, University of Toronto, will be visiting Professor of Medicine for the week.

Dr. Walter McKenzie, Professor of Surgery, University of Alberta, Edmonton, Alta., will also be guest speaker.

Other guest speakers will be announced later.

Prospectus and further information will be mailed at an early date.

J. W. R. Rennie, M.D.,
Secretary.



CONNAUGHT

NPH INSULIN

Following an extended period of clinical trial there is now generally available a modified Insulin preparation known as NPH Insulin. The product is distributed as a buffered aqueous suspension of a crystalline preparation of Insulin, protamine, and zinc. It is supplied in 10-cc. vials containing either 40 or 80 units per cc.



Crystals formed of Insulin, protamine and zinc
in NPH Insulin

NPH Insulin exerts a blood-sugar-lowering effect extending for slightly more than a 24-hour period. In most instances this new preparation has been found to act more quickly than Protamine Zinc Insulin but for a shorter period. Probably because of the fact that NPH Insulin is a suspension of crystals, its use has

been found advantageous in cases where it is desired to administer Insulin and a modified form of Insulin in a single injection without appreciable alteration of the effect of either of the two preparations.

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3. **72% complete relief** — Gray, L. A.: *J. Clin. Endocrinol.* 3:92 (Feb.) 1943.
4. **79% satisfactory relief** — Harding, F. E.: *West. J. Surg. Obst. & Gynec.* 52:31 (Jan.) 1944.
5. **88% complete relief** — Savringhaus, E. L., and St. John, R.: *J. Clin. Endocrinol.* 3:98 (Feb.) 1943.
6. **82% good results** — Glass, S. J., and Rosenblum, G.: *J. Clin. Endocrinol.* 3:95 (Feb.) 1943.
7. **83% satisfactory results** — Freed, S. C., Eisin, W. M., and Greenhill, J. P.: *J. Clin. Endocrinol.* 3:89 (Feb.) 1943.

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In bottles of 8, 15 and 30 cc. with dropper.

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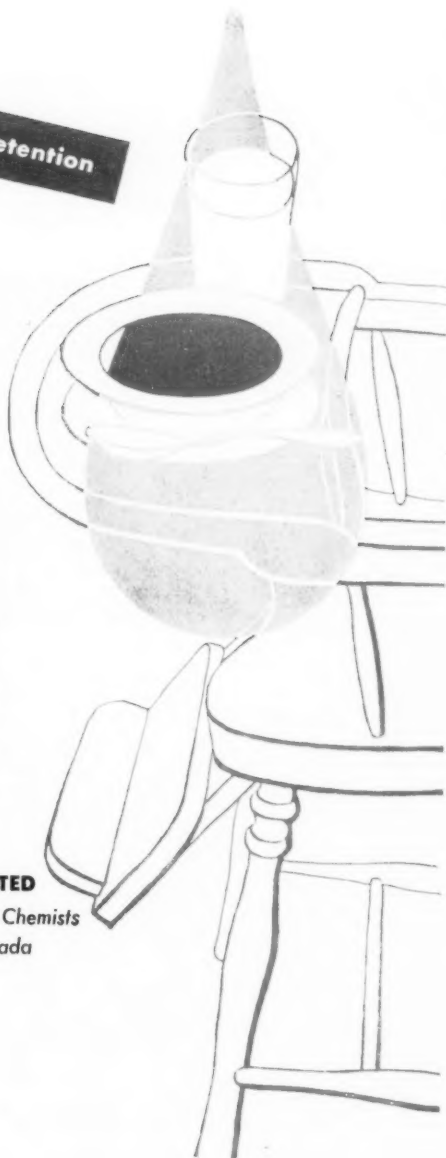
Vitamin A.....	5,000 I.U.
Vitamin D.....	2,400 I.U.
Ascorbic Acid.....	50.0 mg.
Thiamine.....	1.5 mg.
Riboflavin.....	1.0 mg.
Niacinamide.....	20.0 mg.
Pyridoxine.....	1.0 mg.
Calcium d-Pantothenate.....	5.0 mg.
Mixed Natural Tocopherols....	2.0 mg.
(as Antioxidant)	

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In bottles of 8, 15 and 30 cc. with dropper.

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ARTICLE

A New Conception of a National Health Scheme for Australia

Address by the Commonwealth Minister for Health, Rt. Hon. Sir Earle Page, G.C.M.G., C.H., M.B., Ch.M., F.R.C.S., F.R.A.C.S., to the British Commonwealth Medical Congress, Brisbane, 23rd May, 1950.

I have come to offer for your consideration a new conception of a National Health Scheme based on a combination of government aid with nation-wide voluntary insurance against sickness and disease. This means a partnership between the Government and the individual through the union of governmental aid with voluntary effort. This partnership is a recognition that both State and individual have obligations in a national health scheme. Both will benefit—the individual will gain better health, longer life and an easier mind about the expenses of sickness; the State will gain by more efficient production, greater national income and social stability. This partnership will make use of all those factors and organizations that have been built up over centuries to assist restoration of health. This new conception aims to keep everything that is good, and to reject the obsolete. This conception does not destroy any of past advances but makes provision for the use of all future advanced methods by a nation-wide voluntary insurance against sickness. This conception leaves everyone free—the doctor, the patient, the hospital management and staff, the chemist, and the voluntary or insurance organization. This conception keeps alive the element of initiative and competition in service that really produces progress.

This conception gives opportunity for the progressive evolution of better and more extensive medical services without sacrificing the qualitative excellence of Australian medicine. It leaves the Government much freer to help as the cost is distributed between the Government and the voluntary societies. Under this system the Government has strict control over costs. The patient and doctor both have a definite interest in preventing waste and abuse of time, skill, medicine and equipment. Appendices "A" and "B" show the uncontrollable growth of expenditure of the British and New Zealand schemes in the absence of this interest, and the urgent necessity of governmental and individual responsibility.

Difficulties to Overcome

A successful national health policy demands, as indispensable, the willing co-operation of all the providers of health services and benefits. In the last analysis, all medical care must be by individual doctor to individual patient. In actual fact,

therefore, no real national health service can be provided without the willing and wholehearted co-operation of the doctors of the nation. Such co-operation of all the providers of health services is sufficiently difficult to secure in a unitary State where only one Government is concerned. That difficulty is greatly increased in a federation like the Australian Federation. Under the Australian Constitution, the States have the major health powers. The Federal Government has power to control Quarantine, Insurance and certain qualified Medical, Pharmaceutical and Dental benefits. The co-operation of Federal and State authorities is therefore necessary to deal with the whole problem of health and to bring into being as much uniformity in administration as possible. It is, however, not much use discussing co-operation with the States until it is ascertained whether the main providers of the health services will implement the proposal. Therefore, the essential factors of a satisfactory solution must be examined to ascertain whether the providers of medical service are likely to implement it. Especially must the wholehearted co-operation of the most important factor, the medical profession, be ensured.

Essential Factors of a Satisfactory Solution

(1) Its costs must be within the financial compass of the individual and the nation and able to be controlled by the Treasurer.

(2) The plan should contain within itself automatic checks and controls on costs, on abuse of the time and skill of doctors, on the waste of costly medicine and diagnostic equipment, and on the inefficient and uneconomical use of hospital beds.

(3) No interference with personal relationship between doctor and patient.

(4) The patient should be given a definite sense of personal and social responsibility.

(5) The willing co-operation of doctors, chemists, hospital managements, voluntary organizations, insurance societies, etc., should be secured by leaving in their expert hands as much of the administration and control of the scheme as is possible.

(6) Existing agencies and methods that have proved so valuable in the past should be used to the greatest possible extent.

(7) There must be an element of permanence in the plan to permit development and extension of the machinery that can handle with confidence new problems.

(8) The effect of the scheme must be to raise the level and standard of medical care and treatment, and not to degrade it; to build up the self-respect and morale of the people at large, and not undermine it; to stimulate progress in the art of healing and encourage continuous research.

Lessons From Medical History

For our guidance the history and progress of medicine are worth recalling. The practice and

tradition of medicine have been built up slowly, stone by stone, over thousands of years. The ancients used to say that tradition wears a snowy beard. If we destroy our medical tradition, we shall not be able to build it up again in this generation—if ever. Progress in medicine has been the result of many generations of individual thought, study and research, not of Government effort or guidance. Great names stand out: Aesculapius, Hippocrates, Galen—later the great medieval anatomists—later still Hunter, Harvey, Jenner and Lister. All these had to fight opposition of their colleagues in securing the acceptance of their reforms and ideas. What chance would they have had of succeeding had they been compelled to fight Government control as well? The fight against scurvy in the British Navy is sufficient example of this.

Importance of Individual Contact

The healing of the sick is a personal and individual matter, one between doctor and patient. We cannot do it en masse. We must have regard to individual idiosyncrasies. All sorts of psychological factors enter into a cure for each individual.

Sickness is a vitally personal and individual matter to each sick man, sick woman or sick child. Each human being has different allergies. No disease runs an exactly similar course in every person. Its course is determined by the constitution, heredity, previous diseases and condition of other organs. It is obvious, therefore, that human disease cannot be overcome by mass treatment. Successful treatment of the individual will never be effected merely by the exhibition of a stock drug or some set formula of treatment. Successful treatment lies in the cumulative effect of many factors—confidence in the doctor, the efficiency of the treatment, the wise and balanced use of various therapeutic measures, exact diagnosis and consideration of the patient's general condition. All these are helped by the retention of the self-respect of the individual and his pride in his independence. All these factors always applied, and always will apply.

New Factor

But now a new factor has arisen. The practice of medicine is in a critical state by reason of the extraordinary changes that have taken place during the last half century. The rapid advance of its progress in new methods of diagnosis and treatment has placed its traditional methods of practice in danger by the creation of a new class of society—the "medically indigent." The existence of this new class has created a disposition on the part of Governments to attempt to control en masse what is essentially an expert personal matter dealing with the relation of individuals to one another.

Revolution in Medical Knowledge

A revolution has occurred in the nature and scope of medical treatment in the last sixty years.

Our knowledge of the causes of disease has been transformed. The discovery of the germs causing disease has led almost overnight to the development of aseptic surgery, to the utilization of sera, anti-toxins and the possibility of transfusion of blood. The development of electricity and its application for curative and diagnostic purposes have improved the recording of observations and physical conditions.

The discovery of radio activity of uranium, of radium, of X-rays and the relative ease and safety of their use in establishing diagnosis and attacking disease have meant a tremendous advance.

During the two great wars, an immense advance in therapeutic treatment and in the development of specific drugs was made. The theatres of war became huge laboratories. As a cumulative result of all these a rapid development has taken place in specialties of all kinds for diagnosis and treatment, as well as in the manufacture of new powerful drugs. Penicillin which took two wars to establish thoroughly is a special illustration.

Effect on Cost of Treatment

As a consequence, the cost of treatment and diagnosis through the utilization of these improvements has become very much greater than for ordinary medical treatment along the old lines. This extra cost is already at least twice as great and rapidly increasing. There is no provision made on a grand scale for treatment in this great bare area. The result is that today, the occurrence of sudden, serious, or long continued illness or the necessity of a major operation has added such great expense in diagnosis, treatment and hospitalization, as to seriously jeopardize the domestic economy and the finance of the household.

A new race of medical poor has been brought into being. Fear of expense of treatment frequently delays the seeking of early advice and a vicious circle is established. The disease is seen later with the result that longer and more drastic treatment becomes necessary. The patient is sometimes ill for many months instead of days and the diagnosis is then made too late to save life or prevent permanent disablement. Some method must be found of bringing these improved medical and hospital services within the means of the people and of providing the equipment and facilities for such improved services.

Recognition of New Problems

Recognition of the problem of this huge area of treatment that has not been provided for has led to various attempts in different countries to nationalize medical treatment or to give free treatment at the taxpayer's expense. These oversimplified solutions have proved wasteful in their administration, disastrous in their effect on the quality of treatment and destructive of the morale of the people. Effective control was impossible. The willing co-operation of the medical profession

has been lost and Governments have been unable to budget even approximately for their financial commitments or even to limit them. If the quality of treatment declines, National health must suffer and this must occur also if the incentives that previously spurred doctors to give devoted service are being destroyed.

Challenge to Modern Society

The challenge therefore is thrown out to Australia and to every modern society as to how the health of the nation can be improved, the standard and quality of medical practice raised, and modern equipment and adequate hospital accommodation made available, so that advantage can be taken of our great advances in knowledge and the cost still kept within the means of the people. If Australian initiative and intelligence can satisfactorily answer this challenge the best minds of the community will be attracted to the healing art and the future of medicine and medical practice assured. A pattern for all democracies of a National Health Service may be established. If not, the future is very dismal.

The test of success of a National Health Scheme would be that there would be relatively less sickness, better health and less medicine and treatment necessary. The sign of failure of a Health Scheme is that more medicine will be drunk and more treatment becomes necessary.

Necessity of New Approach

Some different approach to this major problem other than Government control by nationalization of health services should be given a trial. I am confident that voluntary insurance, with Government aid, to deal with special classes and to overcome deficiencies in the period and extent of the insured assistance due to the actuarial limitations of the insurance available on the premium charged, will solve the problem. At the same time all the best elements of medical practice which have been gradually built up over many centuries can be maintained. There will be free choice of doctor and no interference with the doctor-patient relationship. Plans and organization decided on will be the result of co-operation between the consumers and providers of the medical service. There will be a minimum of governmental interference and control, and a definite incentive to improved standards.

Advantages of Voluntary Insurance

Why should we turn to an unknown new method? Why not try out on a national scale well-known effective trustworthy methods? For generations, voluntary insurance has been the standard method of dealing with various risks. Voluntary insurance involves a minimum of interference with the traditional life and activity of the community. Voluntary insurance permits the full use of every existing worthwhile agency. Voluntary insurance is well established in everyone's

mind as a reasonable and sensible course to pursue. Voluntary insurance has been invaluable against all unpredictable risks such as sudden death, shipwreck, theft, fire, even the loss of an election or a seat in Parliament. Should not voluntary insurance against unpredictable risks of disease prove just as valuable as in these well tried cases? In fact, voluntary insurance for this purpose, backed by Government aid to cover those bare areas voluntary insurance may be unable to cover completely, seems the only solution that meets the standards required for a satisfactory solution.

The Wide Spread of Voluntary Insurance in Australia

In Australia, many examples of voluntary life, sickness, accident and hospital insurance stand before us. These embrace every walk and condition of life. There are over five million life assurance policies with annual premium payments of over £35,000,000 giving voluntary insurance cover for over £1,000,000,000. Accident and sickness insurance companies cover hundreds of thousands more people. Friendly Societies insure over 600,000 families against sickness and medical treatment amongst other risks. The various hospital insurance funds insure well over half a million. There are many medical and hospital benefit insurance organizations associated with trade unions covering at least another half a million families. Of these, the New South Wales Railway Tramway, Motor Omnibus and Road Transport Employees' Union itself insures 60,000 and there are many others like the Broken Hill Employees' Sickness and Accident Benefit Fund which insures more than 5,000. Voluntary insurance against sickness is therefore a well established principle. Its efficiency can be greatly aided when linked with Government aid to extend and increase its benefits. (See Appendix C).

American Opinion

In 1949, in the United States of America, a National Health Assembly of 800 people, representative of all sections of the community, was called together to discuss this problem. This assembly reached the unanimous conclusion that prepaid contributory insurance should be the basic method of meeting the cost of medical care in order to remove the burden of unpredictable sickness costs and abolish economic barriers to adequate medical services and the indignities of the means test. Voluntary prepaid group health plans offered to members the best of medical care.

This principle of combination of Government aid with voluntary insurance will be applied to the first stage of the National Health Scheme.

The first stage will include such matters as financial assistance to meet the high cost of medical, hospital and pharmaceutical treatment and to assist nutrition of growing children. This stage can be introduced almost immediately. This

financial assistance will be provided out of the National Welfare Fund. Co-operation of the State Governments will be sought on those aspects in which the States can help.

The second more comprehensive stage will deal with questions of capital cost to place the whole national health machinery in an efficient and up-to-date condition. This second stage can finally be dealt with only after exhaustive discussions with State Governments, universities, medical schools, managements of teaching hospitals and of regional base and country hospitals, and with other bodies intimately associated with the care of the sick, with nutrition and with health generally.

Both stages will be designed to ensure a progressive improvement in all phases of the healing art—from teaching and research through to actual practice and the training of medical graduates qualified to deal with all emergencies. Both stages will aim at restoring the position, prestige and fullest usefulness of the general practitioner. His intimate contact and knowledge of the history, constitution, life and circumstances of the patient make the preservation of his opportunities to use to the full all modern improvements in knowledge and technique one of the most important factors in a national health scheme.

Outline of the First Stage

The immediate proposals of the first stage deal with four aspects:

- (a) Nutrition of children;
- (b) Prevention of disease;
- (c) Cost of hospitalization, and
- (d) Cost of medical diagnosis and treatment.

When these aspects are disposed of the comprehensive problems associated with the second stage will be seen more clearly and the separation of current from capital expenditure will be clearly defined.

No Means Test

The scheme imposes no means test. The benefits paid by the Government will be on a flat cash basis for each item of medical service, irrespective of income. Insurers may, however, insure for varying higher benefits.

Features of the First Stage

Features of the four phases of the scheme are:

(i) Improvement of nutrition by the provision of milk daily to all children under the age of twelve years. Distribution of this milk will be arranged in co-operation with State Governments and will relieve State Governments of their present costs in this direction. The practice of the States in this regard is not uniform, and does not cover as wide a range as is now proposed.

(ii) Prevention of disease by a national health educational campaign and by the free provision, on a doctor's prescription, of costly, specific life-saving and disease-preventing drugs, and of drugs necessary for certain chronic illnesses. Abuse will

be checked by professional disciplinary committees, composed of representatives of the medical and pharmaceutical professions.

(iii) Curative measures for serious disease by contributions towards hospital costs and maintenance, through subsidized hospital insurance schemes, provided in such a way as to restore to hospital managements the control of hospital administration. This contribution will both relieve patients' expenses and substantially assist hospital finance.

(iv) The relief of the high cost of medical treatment by combined voluntary insurance and governmental benefit up to 90 per cent of the cost of medical treatment. Abuse of these benefits will be checked and controlled by the patient still paying part of the doctor's fee, and by the supervision of voluntary organizations which disburse the benefit. These organizations will provide from their own funds an amount at least as much as that provided by the Government. Advisory committees of doctors, chemists and voluntary organizations will be formed also to supervise this benefit.

Special provision will be made for medical service to the indigent and to aged, invalid and widow pensioners, the temporarily unemployed and other specially selected classes.

Details of Proposed Medical Benefits Scheme

(i) Benefits should be in the form of Commonwealth subsidy and should be provided as far as possible through the machinery and administration of voluntary organizations which provide for prepaid health insurance.

(ii) The limitations imposed by voluntary organizations in the actuarial calculation of benefits in relation to contributions will be overcome by payment of the Commonwealth subsidy even where no benefit is payable out of the organization's own fund because of limiting conditions relating to maximum benefits, waiting periods, arrears of contributions, etc.

(iii) Voluntary organizations which agree to administer the subsidies must be non-profit-making and will be required to adopt conditions at least equal to an approved standard in the matter of benefits. This will not restrict the organizations in other directions.

(iv) The purpose of the subsidies is to enable the people to obtain as complete a coverage as possible, at low expense to themselves, against expenses of medical services, especially where long and unexpected illnesses occur.

(v) Voluntary organizations will be encouraged to provide coverage against expenses of medical services so that all persons, irrespective of income, who wish to obtain the benefits for themselves and their dependents will be eligible to contribute towards funds.

Prescribed Table of Subsidies

The Commonwealth subsidies to be paid through the voluntary organizations will be set out in a table which will show the appropriate amount for a particular medical service. The table will cover a comprehensive range of medical conditions and procedures. In addition to the ordinary general practitioner consultation service, it will include special services such as midwifery, X-ray, anaesthetics, consultant specialist fees, operations, etc., whether rendered by a general practitioner or a recognized specialist.

Advantages of Scheme of Government Aid Reinforced by Voluntary Insurance

Subsidized voluntary health insurance has the following advantages.

1. A sense of individual responsibility is secured by:

(a) The individual's payment of the insurance contribution, and

(b) The payment by the patient of a small percentage of the fee for every service, as the combined government and insurance benefit is smaller than the actual fee paid to the doctor.

2. Use can be made of existing agencies, thus avoiding setting up costly governmental administrative machinery. Under the proposed scheme, voluntary insurance organizations would pay the greater part of the combined benefit. They thus have a direct interest in the efficient administration of the scheme, and would themselves take steps to prevent malingering and abuse.

3. Government long-term agreements with these organizations are imperative to build up reserves, etc., against epidemic years. These bilateral agreements will ensure the permanence of the insurance scheme.

4. Varying benefits can be offered for different premiums to suit all classes of income as is done with life policies and thus flat rate premiums can be avoided.

5. The inclusion of hospital insurance funds for hospital maintenance releases funds for the provision of additional beds and new equipment, and keeps down the total administration expense rate of insurance organizations.

6. Under this voluntary insurance scheme, the Government has a definite knowledge and control of its share of the cost of the scheme. The insured benefit is equal to, or greater than, the Government benefit. The insurance organization carries the cost of management. The Government's cost must be a sum less than the total premiums paid by the insured contributors, except insofar as the specially selected groups are concerned. A voluntary scheme permits medical and hospital costs of special classes needing governmental aid to be handled by voluntary agencies if desired.

Payment of the Commonwealth subsidies will be made under long-term agreements between the

Commonwealth and the voluntary organizations. Such agreements will be executed where the Commonwealth is satisfied that the benefit of the subsidy will flow to the patient to whom medical services are rendered. The term "voluntary organizations" includes societies, bodies or groups which, or persons who, arrange for the provision of medical services or which provide benefits in respect of medical expenses incurred.

Government Aid Overcomes Voluntary Insurance Limitations

Voluntary insurance has certain limitations:

(i) The scope and duration of voluntary insurance is limited by actuarial determination of the premiums to give specified benefits.

(ii) Contributors may come into or cease their membership of a voluntary insurance scheme as they please.

The Government is taking certain steps to extend the scope and duration of the benefits and to make continuous membership more attractive and easy. The insurance companies can also assist by the terms of their policies.

Government Aid Reinforces Insurance Benefits

The Government proposes to give its cash benefit for each item of medical service and for hospitalization even where the insurance societies' limitation conditions debar a benefit from its own funds. For instance, voluntary insurance organizations do not provide benefits during certain waiting periods after a member has paid his first contribution or after a member has drawn a maximum amount from the fund or when a member is in arrears with his contribution. The Government benefit will be given or continued in these circumstances while the patient is ill.

The insurance societies can encourage continuity of membership by converting any surplus funds into added benefits which accrue after definite periods of membership, say five, ten or fifteen years. An added attraction to insure will come from the fact that the substantial Commonwealth cash benefit for each item will enable the insurance or voluntary organization to offer to the member a lower rate of contribution than it would otherwise provide or to extend the benefits it offers.

In addition to this system of Government aid reinforced by voluntary insurance, the Government in its scheme will take care of the indigent who are unable to insure themselves and also of the medically unfit who are unable to obtain the full range of normal benefits provided by the societies.

Consideration will be given to payment of the Government cash benefit without reinforcement of the insurance benefit to those who, for various reasons, are unable to become members of voluntary or insurance organizations.

Similar methods will be adopted with regard to the proposed insurance for hospital benefits.

The Commonwealth benefit will be in the form of a subsidy paid through the voluntary hospital benefit funds, which provide for prepaid hospital insurance and the Commonwealth benefit will be continued after the insurance benefit has expired, while the patient needs hospitalization.

Conclusion

The partnership of the Government and the individual, and the union of Government aid with voluntary effort to present a united front against disease have been outlined. This system of Government aid reinforced by voluntary insurance to meet costs of unpredictable medical treatment and hospitalization, will permit a much earlier implementation of a national health scheme through the use of existing agencies than any nationalized scheme could do which must create fresh departments and destroy age-old institutions.

In the United States of America, it was anticipated that the preparation of legislation for a compulsory national health scheme would occupy three years, and another three years would be necessary to implement it. Only then could the scheme be implemented by the fullest use of State and Local Governing authorities in the scheme and, even then, only a portion of the American people could be included in the service.

The great advantage of the combination of this system of Government aid with existing voluntary systems is that it does not disturb past practice, but stimulates progressive, orderly evolution of better and better standards. No fresh problems of controls or variation of existing practices are raised. The intimate doctor-patient relationship is retained. The scheme can be proceeded with very quickly because it simply needs an extension of existing organizations which is relatively small compared with the total amount of insurance of all kinds that is constantly being effected.

This new conception of a National Health Scheme can prove the pattern democracy is seeking.

Appendix A (i)

Extract British Medical Journal
March 18th, 1950.

Cost of United Kingdom Health Scheme

	Gross Cost £m.
1946 estimate	167
Original estimate 1948-9x	265
Revised estimate 1948-9x	368
Original estimate 1949-50	352
Revised estimate 1949-50	450
Original estimate 1950	484†

xCalculated on annual basis.

†Assumed.

Each year the increase in actual spending above the original estimate is practically £100 million.

In 1950-51 if the original estimate runs true to form, the revised estimate will be close to £600 million.

In 1950-51 it is estimated that local government and regional authorities will contribute an additional £15 million.

Certain offsets are given against these but these offsets are all contributions from the National Insurance Fund and Superannuation Contributions, the whole of which comes out of the taxpayers' pockets. The total of contributions to these funds is given in the budget papers as £214 million of which £50 million is diverted to health work.

	Original Estimate 1948-49 £m.	Revised Estimate 1949-50 £m.
Pharmaceutical service	16.9	35.3
Dental service	10.8	48.6
Ophthalmic service	3.1	25.1
Total	30.8	109.0

The Australian population is roughly little less than one-fifth of the total British population. A scheme on the British pattern would cost therefore over 100 million pounds per annum to implement, quite apart from the National Insurance aspect which would cost another £40 million at least, even on the British standard which is lower than the Australian pension position. Such a cost would involve an increase of the present Social Services Tax of anything from 50 to 100 per cent in order to enable these costs to be met if such a scheme were adopted.

The scheme proposed by the Australian Government has safeguards that will strictly limit the cost to the estimate. The total Government cost will be a fraction of the present Social Services Tax. The form of administration suggested in the Australian Government's proposals will obviate creation of any large number of new Public Servants to administer it.

Appendix A (ii)

End of "Free" British Health Service National Health

Extract From "the Economist" March 11, 1950

The Economist of March 11, 1950, commenting on these increases said:

"The effect of this rise on Government expenditure is discussed elsewhere in this issue, but what is the effect on the health service itself? If a halt really is called to the rise in cost, how is the Ministry of Health to enforce it? It can continue the only serious attempts at economy it has hitherto made and chip away further at the fees of dentists, chemists and opticians. In this connection it is worth pointing out once again the

serious distortion within the health service caused by the payment of these three groups by items of service. It means that the general practitioners, who are paid a fixed capitation fee, are valued at £47.1 million in the current year compared with the £48.6 million given to the dentists. Even the chemists have earned £35,300,000 or about 75 per cent of the general practitioners' earnings.

"But any reduction in practitioners' fees—unless it were so big that there would be wholesale withdrawals from the service—would cause discontent out of all proportion to the saving in cost. The time has come to save, not ten or twenty million, but a hundred million and even more. The only way in which this can be achieved, and the comprehensiveness of the health service maintained, is to abandon altogether the principle that it should be entirely free. Exactly how a charge should be imposed will need to be carefully thought out (there would certainly have to be a means test to avoid hardship). But it has become quite obvious to all but the most prejudiced that a charge is the only way to bring home financial realities to patients and practitioners as well as to restore the health of the health service itself."

Appendix B

Extract Annual Report of the Director-General of Health, New Zealand, 1949

Cost of New Zealand Medical Scheme

	1941-42	1942-43	1943-44	1944-45	1945-46	1946-47	1947-48	1948-49
Medical Benefits	205,672	1,016,053	1,179,331	1,287,023	1,427,309	1,760,574	2,167,826	2,306,881
Hospital Benefits	1,374,205	1,540,959	2,158,146	2,330,700	2,173,460	1,986,288	1,949,489	1,997,375
Pharmaceutical Benefits	279,968	563,247	762,198	980,237	1,133,366	1,439,686	1,558,350	1,793,159
Total cost of all benefits	2,435,588	3,721,179	4,726,680	5,234,714	5,536,564	6,191,196	6,973,858	7,843,634

These totals do not include administration expenses (roughly £700,000 per year) nor expenses of hospital maintenance which cost £8,981,000 in 1948-49, of which roughly £1,000,000 was capital expenditure.

Comment by British Medical Journal. March 18, 1950

"In short, economies in the Health Service must be made, and must be made now. There are three possible ways of making them. One is by reducing the fees and salaries of the various practitioners. But to make any worthwhile reduction these would have to be on a large scale, which would probably result in wholesale withdrawals from the Service. Otherwise they would merely cause a lot of discontent and save very little. The second is by making a charge to the public for some parts of the Service—for spectacles, wigs, invalid chairs, and appliances. The third way of making economies, and the most equitable and effective, would be to impose a charge throughout the Health Service. This course would certainly not be popular. It would mean the revival of the needs test so that hardship would be avoided. It might mean that cases genuinely needing treatment would go neglected. But can any doctor be certain that that is not happening now, with

crowded surgeries and long waiting lists? In any case there is no real alternative. The time has come to discuss, not whether a charge should be imposed, but the best way of imposing it."

Appendix C

Voluntary Insurance Organizations Types Already Existing in Australia

Cover for Life, Medical, Hospital, Accident and Sickness Benefits

150 hospital insurance contribution funds give cover for over three-quarter million members.

A great number of industrial organizations throughout Australia arrange benefits in respect of sickness, accident and hospital expenses. Of these, 53 are associated with industrial unions, 420 are associated with employees of certain establishments and 97 are organizations initiated and directed by the employers of varied establishments. These give a cover for many hundreds of thousands of beneficiaries.

15 generally recognized major friendly society organizations, many with branches in all States, exclusive of industrial accident schemes cover over

600,000 families with medical benefits.

13 life assurance companies have 5,900,000 current policies.

30 other insurance offices controlling accident or sickness funds, give cover to many hundreds of thousands.

In addition, medical benefits clubs exclusively devoted to medical benefits have been established.

Three voluntary organizations are associated with Local Government.

Quite apart from the voluntary organizations above mentioned, the great bulk of the employees of Governments are contributors to superannuation funds. Many of these contributions are compulsory; but are voluntary inasmuch as the contributor has the right to determine the number of units and therefore the premiums paid and the benefits received.

If the semi-Government organizations be added to the Commonwealth and State superannuation funds, there are in all, 35 such funds throughout Australia.

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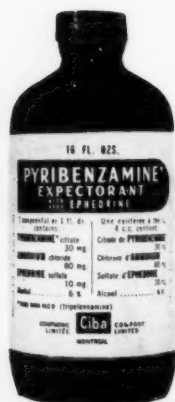
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EDITORIAL

J. C. Hossack, M.D., C.M. (Man.), Editor



Christmas Day



Christmas is the time of remembering. Then we remember our friends with gifts and cheery greetings. Then, also, we remember most acutely those whom we hailed a year ago little thinking that it was for the last time. The thought of these gaps in our circle sobers our mirth. But Christmas is not a time for sombre thoughts. Of all seasons it is the one of gaiety and goodwill, and has been so since time immemorial.

Those ancient watchers who, from their caves, saw the days dwindle and feared that only darkness lay before them, hailed with relief the sun's halt in its retreat and celebrated its regeneration with noise and gaiety. This reprieve from eternal blackness spurred them to an exuberant display of joy and friendliness as is always the case with men who have just escaped disaster. Each year as the phenomenon was repeated the emotions of fear and relief no longer prevailed but the celebration persisted. Moreover it was universal. In Rome it was the Saturnalia or festival of Saturn. Among the Scandinavians Woden was the object of adoration; with the Persians, Mithras; with the Carthaginians, Bel. In every instance the celebration centred around the shortest day and was continued for about a fortnight, just as the modern Christmas season ends on Twelfth Night.

Thus long before St. Augustine preached the doctrines of Christianity to the men of Kent, the character of the Christmas celebration was established, and so difficult was it for Christian teachers to wean converts from their cherished superstitions and observances that the heathen ceremonies persisted with an engrafting upon them of Christian rites. It was easier for the early missionaries to alter the significance of existing pagan festivals than to abolish or replace them.

Of pre-Christian festivals none was more suitable for the celebration of the Nativity than was that of the Winter Solstice. The Roman festival of Saturn—the Saturnalia—was a time of merriment and license. But it was more than that. It was a time of peace and kindness. Then slaves were free to speak and behave as they pleased and were indeed waited upon by their masters. Friends exchanged gifts, houses were decorated with laurel and ever-greens, business was suspended, enmities were forgotten and friendships sealed.

In the bleak north the same rejoicing took place. The Druids gathered their mistletoe, swords were sheathed and no one feared harm from any

source. The same general atmosphere of peace, surrounded the celebrations in Carthage, Phoenicia and the East. Everywhere fires were lit and liquor poured out so that grievances and enmities might be consumed in the one and drowned in the other. Little wonder then that this peaceful and happy season should have been chosen where in to celebrate the birth of the Prince of Peace.

For countless centuries men have at this season proclaimed their longing for a world at peace. For twenty centuries they have sighed and prayed that prophesy may soon be fulfilled, and today not even the shriek of shells or the roar of exploding bombs can drown the Angels' song. The glimpse which we get on Christmas day into a world of peace and goodwill sweetens all hearts. The happiness which we feel, we seek to spread. It is natural, then, at this kindly season to think of those who have fallen on evil times and who have little cause for merriment. Even in our own professional circle there are such, men and widows and children, who feel the pinch of poverty, who are oppressed by care and anxiety, for whom Christmas will stir sad memories. Remember these who were our colleagues or dear to them. Remember them now by strengthening the Benevolent Fund. To do so will give you a double pleasure. First, you will have the satisfaction of giving help where it is needed. Second, you will spread the goodwill of Christmas over the whole year.

Peptic Ulcer

New Methods of Treatment

If figures from the United States are any guide, between 750,000 and 1,500,000 Canadians suffer from peptic ulcer. In a report to the Bureau of Health Education of the A.M.A. Bolton estimated that 5% of the population have peptic ulcer while Palmer, basing his figure on autopsy statistics, places the percentage at 10. Most of the sufferers are men and, for some unknown reason, it is now twice as common after the age of 60 as it was ten years ago.

Whatever may be the explanation for increase in incidence a good reason for its prevalence is the fact that recurrence is the rule. Acquiring an ulcer is like acquiring a spouse because it is usually a matter of "to have and to hold till death do us part." Sometimes the surgeon can bring about a divorce but often his results are only a temporary separation. Sometimes the physician

succeeds very well—for a while, but prognosis for the future is poor and, if anything, becomes poorer after each acute attack.

Hope, however, is constantly being raised as investigators report results of new methods of attack. Medical advance up till now has chiefly been in the use of new antacids. The use of baking soda is now frowned upon to such an extent that even the patent medicine manufacturers advertise that their pills and powders are free from this pernicious substance.

As a matter of fact baking soda is far from being pernicious. There are times when nothing can take its place. One may swallow literally huge doses of magnesium trisilicate and aluminum hydroxide over hours and yet get no measurable benefit. If then a couple of teaspoonfuls of soda are taken in a glass of water there is dramatic relief. First of all there is an eructation of gas so copious as to make one doubt if the other chemicals had any neutralizing power at all. Then comes a comfortable emesis which incidentally gets rid of the excess of soda as well as the gastric contents. Quite often the vomitus reveals the cause for the continued discomfort in a particle or two of solid food—a bit of coagulated egg-white, a fragment of chicken, a particle of starchy food. So long as an irritant is present there is no rest for the stomach or its owner.

Often these irritants are too large to get through a tube. There are times when the use of a tube is desirable but never for the purpose of giving relief in the presence of ulcer. What the tube does slowly, uncomfortably and ineffectively can be done by soda swiftly, pleasantly and most effectively. In the presence of retention nothing can take its place.

Until recently stress has been laid on the need to control hyperacidity. Now it is being generally accepted that still more important is hypermobility. The good results of vagotomy are due to its effects upon mobility, for benefit will follow even when the acidity remains unchanged. If hypermobility, then, be the chief cause of distress, the desirable remedy is one that can remove this cause, and such a chemical has recently been devised.

This is Banthine which is described as "a true anticholinergic agent which seems to block excess stimuli giving rise to the vagotonia" present in peptic ulceration. Its action is two fold. First there is an atropine-like effect which is very noticeable to the patient especially on large doses. Then the mouth becomes dry, the vision blurred, and there may be slight difficulty in urination and a sense of gastric fullness.

The ocular side effects may be quite annoying. Most essential is the recognition of existing or threatened glaucoma. Banthine is definitely contra-indicated where there is any glaucomatous

tendency. The manufacturers also mention that there may be temporary loss of voluntary power due to effects on the cerebral vessels. These two undesirable actions make it necessary to watch the effects carefully when it is used in elderly people. For the young it appears quite safe and there are few contra-indications in middle age.

The second action is an autonomic ganglion blocking effect which brings about the inhibition of acetylcholine at the ganglia of chiefly the parasympathetic but also of the sympathetic nervous system, and at the postganglionic nerve endings of the sympathetic as well. As a result mobility is controlled even to the point where peristalsis is abolished. In this quiet environment with secretion also diminished, the ulcer finds an opportunity to heal. Banthine produces a chemical vagotomy.

The recommended dose is 100 mg. (two tablets) every six hours which, for many patients is a top dose. The discomforts which follow each dose in the early days of treatment becomes less but these unpleasant effects can almost be avoided by starting with doses of 50 mg. increasing later to 75 and then, if necessary, to 100 mg. A heavy patient can tolerate more than a spare one but experience shows that the optimum dose depends more upon the size and activity of the ulcer than upon the size of the patient. At the beginning it is well to order a "sloppy" diet, and alkalies also may be used but before long both of these adjuncts are unnecessary, but even when patient is symptom-free and the x-ray shows a healed lesion at least half doses should be taken to avoid recurrence. From results observed so far Banthine is a very valuable remedy.

"The Use of Water-soluble Chlorophyll in the Treatment of Peptic Ulcer of Long Duration" is the title of a paper published in *The Review of Gastroenterology* (May, 1950), by W. G. Offenkranz. The author says of his 74 patient that 60 experienced complete symptomatic relief in from 1 to 3 days, and in cases followed up to 11 months there were no recurrences. These patients followed no diet, smoked as they pleased and drank as they wished.

The amount of chlorophyll given is not stated. Apparently it was used alone and also in combination with aluminum hydroxide and magnesium trisilicate, but details of treatment cannot be given. However water soluble chlorophyll is available in the form of "Sudoma" and this is not toxic, therefore in the absence of more precise instructions it might be satisfactory to prescribe two or three 100 mg tablets on rising, 90 minutes after each meal and on retiring. The claim is that chlorophyll has a local healing action. It would follow that its effect would be greatest in a quiet stomach and therefore that it could very well be combined with Banthine.

Banthine produces a chemical vagotomy, chlorophyll promotes local healing and procaine controls pyloric spasm. The drinking slowly of 100 cc. (or even 50 cc.) of a 1% solution of procaine will bring about almost complete paralysis of the pylorus in 10 minutes and the effect persists for some hours gastric mobility, in the meantime, remaining unchanged. Roka and Laitha (B.M.J., May - 0, 1950), report excellent results in functional spasticity as well as in that due to ulcer and cancer. Procaine makes it possible for cancer patients to be fed naturally and, by correcting malnutrition, to fit them for operation. It has also been used successfully to control chronic vomiting in gastric ulcer.

These three new methods of treatment hold out much hope to sufferers from gastric disease, and hold out, also, the promise that the prognosis for peptic ulcer may be no longer gloomy.

Books for Christmas

No present is more fitting than a book. It lasts a long time and is a constant reminder of the friendship that exists between donor and recipient. Herewith is a list of books well worth trying as presents to your friends (and as presents from yourself to yourself if you don't possess them).

First of all here are some titles especially suited to the needs of students:

Aids to Medicine—A very compact little book which students of all years will find most useful for purposes of review and revision. Macmillan, \$1.40.

Wheeler and Jack, **Hand book of Medicine**—for generations students have found this little book (350 pages) a useful help. A new edition has just been published. It is ideal for third year students and of almost equal value to students in later years. It is concise, well illustrated and emphasizes the essential points in the diagnosis and treatment of the ailments discussed. Macmillan, \$3.50.

Medical Management is a pocket-size volume of pages. It gives terse, concise instructions on the treatment of all the common and some of the less common disorders. Tables and diagrams increase its convenience. U. Medical Publishers, \$2.50.

A companion volume to the above **The Physician's Handbook** is a pocket-sized encyclopedia of diagnostic procedures. These two books are ideal gifts for senior students and internes, but they will be appreciated by your friends as well. University Medical Publishers, \$2.50.

Clark-Kennedy's **Medicine** should be on your own shelves. It would make a most acceptable gift to anyone either student or practitioner. It is not a systematic recounting of signs, symptoms, diagnosis, etc., such as is the case with the regular textbooks. It is a treatise upon the art of medicine. It deals with the patient and his reactions. It is beautifully written and in addition to being in-

structive it is thought-inspiring. The two volumes (thanks to the devaluation of the pound) cost \$8.50. It will delight yourself and your friends. Macmillan, two volumes, \$8.50.

There are two recent volumes of daily usefulness which will delight anyone who gets them. First is **Diagnosis in Daily Practice**, by Geschickter and White. It is copiously and beautifully illustrated, contains an abundance of tables and is the sort of volume that finds itself on one's desk rather than on the library shelves.

The other book is its companion. **Analysis and Interpretation of Symptoms**, by C. McBryde. In it a number of common symptoms are investigated from the stand point of their physiology and pathology. Again, here is a book most helpful to senior students and equally illuminating to those in practice.

Finally, if you wish to give a frequent reminder of your thoughtfulness send your friends subscriptions to the **American Practitioner**. It was one of the top journals even before it incorporated The Digest of Treatment. Now it is for G.P's. the top journal. It is published by Lippincott at \$10.00 the year.

Unless times have changed dermatology remains a top puzzle for most doctors. It need do so no longer, however. We published reviews of two very worthy volumes—**Essentials of Dermatology** (Lippincott) and **Regional Dermatological Diagnosis** (McAinsh). The "Essentials" is a well illustrated compendium which deals with all the common ailments and quite a few that are unusual. The other book is based on the fact that lesions have preferences in location. Once you know where the process is active you have only a limited number of diseases to think about. They are all set forth in comparative tables, then by looking up in the text the condition suggested treatment becomes easy. It is really an excellent idea, well carried out. **Essentials of Dermatology**. McAinsh, \$7.50.

Every book we have mentioned is of the high merit. You will want to have most of them.

You can get any of these volumes on approval, or have them sent as gifts to your friends, simply by naming the title, the name of those whom you wish to remember and your own name and address with the desired method of payment. You won't regret it neither will those of whom you are mindful.

The addresses of the publishers are listed below: Macmillan Publishing Co. of Canada Ltd., 70 Bond Street, Toronto 2, Ontario.

J. B. Lippincott Company, 2083 Guy Street, Montreal 25, P.Q.

McAinsh & Co. Ltd., 388 Yonge Street, Toronto, Ontario.

University Medical Publishers, P.O. Box 761, Palo Alto, California, U.S.A.



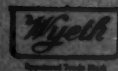
... and the
little
woman!

Santa is not the only one who is busy. The little woman who looks after the small fry, does the shopping, cooks the meals and looks after many of the details of running a household efficiently, is especially busy during the Christmas season.

The unceasing demands of a properly functioning household, can play havoc with a woman. To cope with the situations that arise, requires "iron" nerves. Even the "iron woman" may wilt and when she does the hidden cause may be that she has not enough iron in her blood. Nutritionists at Cornell University estimated that to hold her own, a woman must derive at least 10 to 11 milligrams of iron from her diet. Such a diet is not easily provided. When iron deficiency saps a woman's strength and strains her nervous energy, Hematinic Plastules can do wonders to restore her well-being.

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SOCIAL NEWS

Reported by K. Borthwick-Leslie, M.D.



Dr. Horace C. Norquay, son of John Norquay, Premier of Manitoba, 1878-1887, was honored at his home in Selkirk, Man., on the occasion of his 81st birthday. Dr. Norquay served as medical officer for the Department of Indian Affairs at Norway House and North Battleford for 25 years. Since his retirement, 13 years ago, he has resided in Selkirk. Many interesting tales of his early life and activities were related and read the publishing of "Memoirs."

Remembrance Day Service at St. Margaret's Church was devoted to the memory of Dr. Ellen Douglass. Prayer books donated by the St. John Council of the Ambulance Brigade were dedicated to her memory, and following the service an excellent likeness of Dr. Douglass, donated by the Fort Garry Nursing Division No. 2, was unveiled and also dedicated to her memory. The picture now hangs in St. John House.

Lt.-Col. G. L. Morgan-Smith, of Prairie Command, with his family will leave early in January for Queenscliffe, Australia, where the Colonel will attend a course at the Australian Staff College. Although we will all miss Lt.-Col. Morgan-Smith, we extend to him the "best of all good things" wishes and an envious bon voyage.

Dr. Wallace Grant, Superintendent of the Children's Hospital, who is at present doing post-graduate work at Yale University has been invited by President Truman to attend the Mid-Century White House Conference on Children and Youth, in Washington, Dec. 3-7. Wally is officially Manitoba's representative at the conference, and will, for sure, "do us proud."

Miss Shirley MacCharles, daughter of Dr. and Mrs. M. R. MacCharles, left last week for Honolulu where she will reside. From Manitoba to Honolulu right now certainly appeals. I could do with some grass skirt climate.

Can't help but wonder what Dr. Lerner's home on Scotia St. will do with its stilts, next year if another cyclone hits simultaneously with the flood—what a splash, or am I being pessimistic?

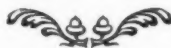
Mrs. C. A. Adamson, Berkeley, Cal., is visiting her son and daughter-in-law, Dr. and Mrs. Patrick Adamson.

Dr. W. I. Easton, Selkirk, Man., has been holidaying and "observing" in New York, also Dr. M. M. Pierce recently returned from New York, but I haven't had time to glean any details of his sojourn there.

So many of our confreres tripped hither and yon, it has been impossible to catch up to them, but I hear that Dr. Donna Huggins is leaving for the Eastern States, including Hartford, on a speaking tour.

Time does ramble along. Russ and Mrs. Cleave, with the wedding of their daughter last week, and in Minnedosa Dr. and Mrs. I. K. Gilhuly lost their son in matrimony, or does one gain a daughter under those circumstances? First thing I know, I'll find out, the hard way.

Happy Christmas and a Merry Prosperous New Year.



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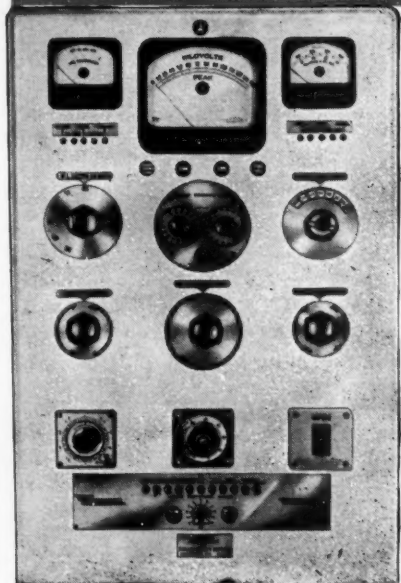
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ASSOCIATION PAGE

Reported by M. T. Macfarland, M.D.



Highlights of the 1950 Annual Meeting of the Association

Activities began on the evening of October 2nd, when, in the Vice-Regal Suite of the Royal Alexandra Hotel, the President's dinner to the retiring Executive was a decided success, marred only by the fact that the Executive Committee was called into session in the Windsor Room for a meeting which lasted till nearly midnight.

Guest Speakers

Guest speakers were Doctors Norman H. Gosse, President, Canadian Medical Association; J. W. Abbiss, Assistant Professor of Pathology, Dalhousie University, Halifax; H. B. Atlee, Professor of Obstetrics and Gynaecology, Dalhousie University, Halifax; F. W. Jackson, Director of Health Insurance Studies, Department of National Health and Welfare, Ottawa; Victor Johnston, President, Section of General Practitioners, C.M.A., Lucknow, Ontario; Leonard T. Kurland, Department of Epidemiology, Johns Hopkins University, Baltimore, Maryland.

Places of Meetings

Scientific sessions were held in the Crystal Ball Room, while the Banquet Hall was used for the Commercial Exhibits and the Colonial Room for the Scientific Exhibits. The Chairman of the Scientific Programme Committee, Dr. C. E. Corrigan, had arranged for Clinical Sessions to be held on Tuesday morning, October 3rd, at St. Boniface Hospital, and on Thursday morning, October 5th, at the Winnipeg General Hospital. Tuesday evening a dinner was given by the General Practitioners' Association of Manitoba, and was addressed by Dr. Victor Johnston, Lucknow, Ontario. The Wednesday luncheon in the Tea Lounge was addressed by Dr. N. H. Gosse, President of the Canadian Medical Association, while Dr. T. C. Routley attended the Rotary Club luncheon. The business session of the Association was conducted on the afternoon and evening of Wednesday, October 4th. Through the courtesy of the Winnipeg General Hospital, luncheon was provided on Thursday with Dr. F. W. Jackson the speaker, and the major social event of the Convention was enjoyed in the Crystal Ball Room. A tea was arranged by the wives of the Executive Committee members for Tuesday afternoon, October 3rd, and was held in the Professional and Business Women's Club, Evergreen Place. The Commercial Exhibitors were greatly pleased with the success of the meeting, which, they avowed, was the best which they had attended during the current year.

Attendance figures were:

Members of the Association	308
Visiting Doctors	19
Internes and Students	126

Total 453

Nominating Committee

June 20th—Letter addressed to the seven District Medical Societies, requesting name of representative to Nominating Committee.

July 4th—Second letter sent to six District Medical Societies, from whom reply had not been received, requesting name of representative without delay.

August 4th—Notice of meeting of Nominating Committee sent to all members, including two Past-Presidents of the Association.

August 14th—Meeting of Nominating Committee called for 7 p.m.

August 14th—Tentative slate of nominations submitted to Executive Committee and approved by that body.

August 15th—Each nominated candidate contacted to inquire if he would allow his name to stand. Additional time requested in some cases.

August 31st—Combined August-September issue of the Review published.

September 10th—Deadline for October issue of the Review. One nominee for member-at-large, rural, who had accepted nomination had joined the Canadian Army Special Korean Force and already reported for duty.

September 25th—Unlikely that the Manitoba Medical Review will be published prior to the Annual Meeting.

October 2nd—Minutes of Executive Committee, August 14th, with list of nominations for presentation to the Annual Meeting included, approved by the Executive Committee.

October 4th—Fourth item of business at the Annual Meeting—Nominations of Officers for the ensuing year. The President prefaced his remarks by the statement that at the meeting which was called only two members of the Nominating Committee were present, and the matter was referred to the Executive Committee, "the responsible agent of the Association for the transaction of its affairs." While the Executive Secretary posted these nominations on the blackboard, the explanation was provided by the President as to procedure followed, and the question was asked whether there were any other nominations. In accordance with the Constitution, which states that officers "shall be elected from nominations, one or more names for each office," several single nominations were made,

but the fact was fully explained to the members by the President. It is, of course, regrettable that the attendance at the Annual Meeting was small, but the balloting for officers represented the average of the number of votes recorded in recent years.

Committee Reports

The Committee Reports submitted to the 1950 Annual Meeting of the Association were printed in toto in the October issue of the Review. These reports were considered at the meeting of the Executive Committee held on October 2nd, in anticipation of the Annual Business Meeting. Arising from the final meeting of the Executive Committee and the Annual Meeting, the following resolutions were adopted:

Municipal Doctor Practice

"THAT, inasmuch as the Municipal Doctor Contract does not provide a complete medical service, it is hereby resolved that the Manitoba Medical Service be made acquainted with the problems of those living under a Municipal Doctor Contract, that they approach the Municipal Council and the Provincial Government, to determine if they can sell these citizens the proposition of a full contract under the Manitoba Medical Service."

Re Prepaid Medical Care Plans

"THAT Manitoba Division agrees in Provinces, where the Division has not a professionally-sponsored medical care plan, that those Divisions may elect or declare any other prepaid medical scheme as their representative on a national coverage plan basis.

THAT, in view of the experience which the profession has had heretofore in Canada in several of the Divisions in the establishment of prepaid medical care plans under the guidance of the medical profession, that all Divisions be urged to give sympathetic consideration to the establishment of such plans, wherever they may be feasible."

Re Contract Practice

"THAT the Executive be requested to appoint a special committee to study contract practice in Manitoba, and bring in a report with recommendations at the next Annual Meeting."

Re Public Relations

"A step has been taken to educate a large percentage of the public who are unaware that the work done on the public wards by the attending staffs is performed without financial reward. Printed cards to this effect will shortly appear in the Winnipeg General Hospital and this matter is under consideration at the St. Boniface Hospital.

The C.M.A. Public Relations Committee has suggested that public addresses be given throughout Canada by members of the profession and are about to send us recommended talks.

In the last analysis, of course, the most important public relations task any doctor can perform on his own behalf, and on behalf of the whole profession, is to do conscientious work, and to maintain a sense of fair play when making out bills."

Re Workmen's Compensation Board

"THAT this motion (referring to agreement between the Manitoba Medical Association and the Workmen's Compensation Board) be referred back to the Executive Committee, to be put into force when and if the Executive Committee deem it necessary."

Re Laboratory and X-ray Units

"THAT the report of the special committee of the Advisory Commission, under the Health Services Act, be noted and that the criticisms of the Laboratory and X-ray Units at Dauphin and Selkirk, with the recommendations embodied in the Report, be adopted by this Association."

Re Manitoba Medical Service

"WHEREAS prepaid medical care is now available in practically every province in Canada, and WHEREAS nationally employed groups wish to be insured only on a national basis, and

WHEREAS a Trans-Canada medical service plan, that is actuarially sound, that will provide for common contract and rate structure, and that will conform and co-operate with the other plans across Canada, is the ideal for which all Prepaid Medical Care Plans are now striving;

THEREFORE, BE IT RESOLVED, that the Manitoba Medical Service be requested to alter its present plans of insurance so as to conform with the plans that are now available for prepayment of medical care across Canada and that have been endorsed by the Canadian Medical Association and by the recent meeting of representatives from all the Prepaid Medical Care Plans of Canada."

Appreciation

RESOLVED that the Manitoba Medical Association in Annual Meeting assembled thank:

1. The Royal Alexandra Hotel for its assistance in providing facilities for the Annual Meeting;
2. The Ladies' Committee for its excellent work in providing entertainment for the visiting ladies;
3. The Press of this City for its co-operation in giving prominence to this meeting;
4. The Radio Stations of this City for their co-operation in giving prominence to this meeting;
5. The parent organization, the Canadian Medical Association, for its assistance in providing the services of Dr. T. C. Routley, General Secretary; Dr. Norman H. Gosse, President; Dr. J. W. Abbiss, Dr. H. B. Atlee and Dr. Victor Johnston;
6. The President, his Executive, and the many committees for their untiring and successful efforts on behalf of the medical profession;
7. All the speakers for the contribution they have made and are to make on our behalf.

8. The Winnipeg General and St. Boniface Hospitals for their co-operation in providing facilities for Clinical Sessions.

Election Results

President Dr. Eyjolfur Johnson, Selkirk
1st Vice President Dr. A. M. Goodwin, Winnipeg
2nd Vice-President Dr. C. W. Wiebe, Winkler
Hon. Secretary Dr. C. B. Schoemperlen, Winnipeg
Hon. Treasurer Dr. Ruvin Lyons, Winnipeg
Winnipeg Member at large Dr. Harry Medovy
Rural Members at large: Dr. R. W. Whetter,
Dr. S. S. Toni (to replace two-year unexpired term of Dr. Wiebe).

Representatives From District Medical Societies 1950-1951

Brandon and District Medical Association—
Dr. R. F. M. Myers, Brandon.
Central District Medical Society—
Dr. J. C. Rennie, Portage la Prairie.
Northern District Medical Society—
Dr. W. G. Ritchie, Dauphin.
Northwest District Medical Society—
Dr. J. E. Hudson, Hamiota.
North of 53 District Medical Society—
Dr. C. S. Crawford, The Pas.
Southern District Medical Society—
Dr. W. H. C. North, Carman.
Winnipeg Medical Society—
Dr. A. E. Childe, Winnipeg.

Appointed Representatives to Executive Committee

Medical Faculty Council Executive—
Dr. E. F. E. Black.
Manitoba Health Officers' Association—
Dr. Paul L'Heureux.
College of Physicians and Surgeons of Manitoba—
Dr. Edward Johnson and Dr. C. B. Stewart.

Nominations to the Board of Trustees, Manitoba Medical Service

Doctors F. G. Allison, W. J. Boyd, A. Hollenberg, A. R. Birt.

Nomination for Senior Membership in the Canadian Medical Association, 1951

Dr. H. S. Sharpe, Brandon.

Past President's Certificate

On the occasion of the Annual Dinner, Dr. D. L. Scott, President, made presentation of the Past President's Certificate to Dr. Harold S. Evans, in token of appreciation for services rendered during the presidential term, 1948-1949.

"A New Conception of a National Health Scheme for Australia"

Considerable interest has been shown by the Executive Committee and the Association in the copy of an address delivered by the Right Honorable Sir Earle Page, Commonwealth Minister for Health for the British Commonwealth Medical Congress at Brisbane, Australia, in the spring of this year.

Through the good graces of the Manitoba Medical Service, copies of the address were made available to Executive Committee members, and Dr. T. C. Routley advised that the plan had received approval in principle from other provinces, notably, Saskatchewan Medical Association. Manitoba Division recommends further study by the Canadian Medical Association.

D.V.A. Hospitals

The scheme whereby non-entitled veterans would be admitted to D.V.A. Hospitals at a per diem rate of \$8.65, was on trial for a six-month period, and will likely come up for review at the next meeting of the Canadian Medical Association Executive in Montreal. An informal report by members of the Committee appointed by the Executive indicated general opposition to the plan as outlined in a resolution of the Victoria Medical Society, prior to the Annual Meeting of the Canadian Medical Association in Halifax. The resolution of that body as incorporated in the minutes of August 14th, was agreed, in principle, with the substitution of Clause No. 7 as follows:

"THAT the Staff Members of the D.V.A. Hospitals be asked to work out a plan whereby no rift in the relationship between the non-D.V.A. Members and themselves might be caused by any barring of non-D.V.A. Members from the Staffs of D.V.A. Hospitals."

C.M.A.—Canadian Red Cross, National Disaster Services Institute

A letter from C.M.A., dated October 6th, in which was enclosed letter from Dr. Stanbury, National Commissioner of the Canadian Red Cross Society, requested Dr. Routley to participate in a National Disaster Services Institute, to be held in Winnipeg on November 23rd. As Dr. Routley is unable to attend, he asked the Manitoba Division to appoint someone in his stead. On resolution, it was agreed that the Executive Secretary be appointed to attend the National Disaster Services Institute as an Observer.

Workmen's Compensation Act

Information was received through the local papers that the Minister of Labour and officials of the Department would sit on November 1st to receive briefs on proposed changes in the Act. The matter was referred to the Legislative Committee of Fifteen, which met on October 24th, and empowered a sub-committee of four to secure legal advice in the preparation of a suitable brief.

Trans-Canada Medical Plan

The following resolution was adopted by the October 22nd meeting of the Executive Committee:

"THAT the Manitoba Division, C.M.A., affirm approval in principle and support for the proposed Trans-Canada Scheme for the provision of prepaid medical care, and

REQUEST the Board of Trustees, Manitoba Medical Service, to outline any changes which the proposed Trans-Canada Scheme would make in the policies which have been approved by this Division.

IT IS FURTHER REQUESTED that these changes be submitted to the Executive Committee of the Manitoba Division, C.M.A., for study, prior to meeting of Executive Committee (November 12th), in order that any suggestions may be made to the Board of Trustees prior to the meeting of the C.M.A. Executive and the Conference of Pre-paid Medical Care Plans."

Subsequently on October 31st, the information was received from the Executive Director, Manitoba Medical Service, outlining the differences between the two plans. This information was passed to Dr. R. W. Richardson, in his dual role as Chairman, Committee on Economics, and representative from this Division to the Executive Committee of the Canadian Medical Association.

Manitoba Medical Service

Statements submitted to the Committee on Economics by a private member of the Association re Manitoba Medical Service:

(1) Solvency of the comprehensive plan is incompatible with:

- (a) Clinical freedom of the physician.
- (b) Freedom of the patient to initiate services at any time.
- (c) The rate of premium within the capacity to pay of most wage earners in lower income group without subsidies.

(2) Solvency of a plan is possible on certain basic principles of insurance.

The adoption of the latter would exclude several services and the provider of these services, i.e., physicians, from a share in the revenue of the plan.

Is a plan of this type contemplated by the medical members?

These two propositions are submitted for evaluation and to elicit a directive or statement of policy from the Committee on Economics, as there is a lack of knowledge and much confusion in the thinking of the members on this topic of solvency.

An Insurance Company can be solvent.

The M.M.S. can be solvent.

The means are drastic in effect.

Committee on Economics

Reply to the statements re the Manitoba Medical Service:

Heading No. 1 (a) (b) (c) is a statement of which the Committee on Economics can agree fully without discussion.

Heading No. 2 is a statement with which we also agree.

These two propositions have been submitted for the purpose of eliciting a statement of policy from the Committee on Economics.

To our knowledge no general policy has ever been written down by the Association specifically for the guidance of the M.M.S. Board. This has been avoided purposely, because the M.M.S. is a separate corporate body and has complete autonomy. Any request from the M.M.S. to the Association for guidance is because all the Medical Members can be approached as a group through the Association.

The Committee on Economics and the Association probably should express their opinion on policy for the M.M.S. from time to time, fully realizing that it is only their opinion and may, or may not, be accepted as the Board of the M.M.S. concurs or rejects.

At Annual Meetings or by Executive action, the Association has expressed opinions on certain specific matters, such as Income Limitation of Subscribers, Fee Schedules, etc., but these cannot be taken as a broad general policy.

Only a brief outline can be given here of what the Committee on Economics regards as a general policy for the M.M.S. to follow at the present time.

Our profession, through the years, has searched for a system of medical practice that would co-operate with humanitarian efforts to furnish a medical service to the whole population and has pressed for the highest possible standard in such services. Experiments by the governments of some states to accomplish this have been failures, particularly in the standard of medical care offered. For this reason alone, the profession in Canada is justified in resisting any deterioration of our standards by state scheme, which, although having a popular or political appeal, would actually give less real medical care.

Many members of the profession are tending to forget for what reasons the Association was instrumental in forming the M.M.S. and why we are supporting its continuance. Our reasons can be frankly listed:

(1) To answer a demand from the public for some system of spreading the costs of medical care over the community on a prepaid basis.

(2) To check the state from meeting that demand by it offering the public some form of compulsory medical care in which we would be forced to accept political intervention between patient and doctor.

(3) To find some facts and figures about the actual costs of supplying such medical care in case we were faced by the implementation of such a scheme by the state.

(4) To set up a scheme

(a) in which the profession would have adequate representation, rather than have the state set up a scheme in which the profession would

have little or no control and be subject to political pressures;

(b) in which, although at first only applying to those subscribers who could pay for their medical care, might later be subsidized by government to include the medical indigent and those not able to afford the full premium;

(c) that, being a non-profit plan, could give a greater coverage for less than commercial companies, realizing that commercial insurance alone would not fully satisfy the public demand nor deter the politicians from making big fellows of themselves with other people's money;

(d) that would, as nearly as possible, permit all members of the profession to share equally in the controls, losses and sacrifices that would be inevitable with such a plan.

The scheme was a new departure in medical practice. It was not something particularly wanted by the profession. It meant someone regulating our former methods and subjecting us to outside control but, at least, it would be by those of our own choosing and mostly of our own profession. It meant filling out more forms, abiding by a rigid fee schedule and having our work scrutinized by outsiders. It was fully realized by the founders that it would mean a lesser income for some years and such was the case. Whether or not this applies at the present time is debatable.

All this was accepted at first as a necessity and as the lesser of two evils. What we must remember is that the necessity for this scheme is even greater today than when it was started.

There has been discussion again by Medical Members and the Board about "making the plan solvent" and "placing it on sound insurance principles." Of course, it is desirable to achieve these, providing we do not jeopardize the aims we set out to obtain.

If making the plan solvent means stopping the growth of the plan, or even losing subscribers, we shall have no plan that will prevent us having the greater evil of a state compulsory scheme forced upon us. If sound insurance principles mean losing our subscribers, or not satisfying their demands, the same is true.

The Board should be encouraged to place some restrictions on some types of work which would make all Medical Members share equally the losses of this plan, if such restrictions would be in keeping with its growth.

This Committee, therefore, would consider that our general policy should be to maintain the aims of the plan as outlined above. It would hope that the Board of the Manitoba Medical Service would keep those aims in mind in its deliberations and resist any pressure to abandon them in order to build up a profitable and well-run insurance company.

The plan must compete with many others and only the Board can decide at what point we meet this competition without losing sight of our true objectives. If the Board feels that we cannot compete and maintain any worthwhile portion of our aims, the Committee feels that at that time we should abandon the scheme.

The Committee on Economics would welcome any further references from time to time to take before the Association in matters of general policy.

Submitted to and adopted by the Executive Committee, Manitoba Medical Association, Nov. 12, 1950.

Standing Committees, 1950 - 1951

Archives—Dr. Athol Gordon, Chairman.

Constitution and By-laws—Dr. Murray H. Campbell, Chairman; Dr. E. J. Skafel, Brandon.

Credentials and Ethics—Dr. I. O. Fryer, Chairman; Dr. J. C. Rennie, Portage la Prairie; Dr. R. P. Cromarty, Brandon.

Economics—Dr. R. W. Richardson, Chairman; Dr. Elinor F. E. Black; Dr. Ruvin Lyons (with power to add).

Industrial Medicine—Dr. H. M. Malcolmson, Chairman; Dr. Jack McKenty.

Maternal Welfare—Dr. C. C. Henneberg, Chairman; Dr. Henri Guyot, Dr. Cherry K. Bleeks, Dr. J. E. Hudson, Hamiota.

Medical Education—Dr. L. R. Coke, Chairman; Dr. L. Cherniack, Dr. L. J. Mongeon, Dr. J. P. Gemmell.

Membership—Dr. Ruvin Lyons, Chairman (with power to add).

Nutrition—It was suggested that as this committee has not been active for several years no appointments be made unless need arises. Agreed.

Pharmacy—Agreed no appointments be made to this committee unless need arises.

Public Health—Dr. Roper G. Cadham, Chairman; Dr. R. W. Whetter, Steinbach; Dr. M. R. Elliott, Dr. Paul L'Heureux.

Editorial Board, C.M.A. Journal—Dr. Ross Mitchell, Chairman; Dr. Athol R. Gordon.

Editorial—Dr. J. C. Hossack, Chairman; Doctors S. S. Peikoff, Ruvin Lyons, S. Israels, K. Borthwick-Leslie, D. W. Penner, Paul T. Green.

Cancer—Representatives to Cancer Relief and Research Institute constitute members of Cancer Committee.

Representatives to Cancer Relief and Research Institute—Dr. C. E. Corrigan, Chairman, 1 year, term expires 1951; Dr. K. R. Trueman, 2 years, term expires 1952; Dr. Elinor F. E. Black, 3 years, term expires 1953.

Representatives to Legislative Committee of Fifteen—Dr. Ross H. Cooper, Chairman; Dr. Murray H. Campbell, Dr. J. C. Elias, Morris; Dr. G. H. Hamlin, Portage la Prairie; Dr. F. A. L. Mathewson, Dr. W. B. MacKinnon.

Extra Mural—Dr. Paul K. Tisdale, Chairman; Dr. D. S. McEwen.

Historical Medicine and Necrology—Dr. Athol R. Gordon, Chairman.

Workmen's Compensation Board Medical Referee Committee—Dr. C. E. Corrigan, Chairman, 4 year term, expiring 1951; Dr. F. G. Allison, Vice-Chairman, 4 year term, expiring 1953.

Representative to Post-Graduate Committee—Dr. A. Hollenberg.

Representative to Manitoba Sanatorium Board—Dr. M. B. Perrin.

Group Insurance—Dr. L. R. Rabson, Chairman.

Liaison Committee, C.P. & S.-M.M.A.—Dr. Eyjolfur Johnson, Selkirk; Dr. D. L. Scott, Dr. H. S. Evans, Brandon.

Pension Committee—Dr. M. S. Hollenberg, Chairman; Dr. F. G. Allison, Dr. Eyjolfur Johnson, Selkirk; Dr. C. B. Schoemperlen, Dr. J. C. Rennie, Portage la Prairie.

Representative to Advisory Commission, Health Services Act—Dr. C. W. Wiebe, Winkler, three-year term, Oct. 15, 1950.

Public Relations—Dr. F. G. Allison, Chairman; Dr. L. A. Sigurdson.

Fee Committee—The President (Dr. Eyjolfur Johnson) or his delegate, first or second vice-president.

One General Practitioner—Dr. P. H. McNulty.
One Specialist—Dr. C. H. A. Walton.

Workmen's Compensation Board Negotiating Committee—Doctors C. H. A. Walton, C. M. Thomas, C. B. Schoemperlen, P. H. McNulty.

Advisory Committee to the W.C.B. Negotiating Committee—Doctors Henry Funk, A. Hollenberg, P. H. McNulty, F. D. McKenty, C. M. Thomas, Portage la Prairie; R. W. Richardson.

Workmen's Compensation Board Fee Assessment Committee—Doctors C. W. Burns, W. A. Gardner, Chas. Hollenberg, F. A. Macneil, P. H. McNulty.

Physicians' Pocket Reference

Under date of November 1st, the Department of Health and Public Welfare forwarded a copy of Physicians' Pocket Reference to the International Statistical Classification of Diseases, Injuries and Causes of Death, 1950, to all doctors in the province. Should any member fail to receive his copy he may address his communication to Dr. M. Bowman, Director, Preventive Medical Service Section, Department of Health and Public Welfare, Legislative Buildings, Winnipeg, or Miss L. E. Stewart, R.N., Acting Recorder, Vital Statistics Division, Department of Health and Public Welfare.

Canadian Society of Laboratory Technologists

Preparations are under way for a meeting of the Canadian Society of Laboratory Technologists to be held in Winnipeg on the week of June 24th,

1951. Members of the profession will probably be asked for assistance in connection with the meeting.

Annual Meeting, 1951

It isn't too soon to be thinking about plans for the next Annual Meeting. Hotel accommodation has already been requested, and before long, it will be necessary to name committees in order that early contact may be made with speakers, Commercial Exhibitors, Scientific Exhibitors, etc., in order that the doctor or his receptionist may put a red circle around the dates and attempt, in these busy days, to prevent overlapping or conflict. New and stimulating ideas will always be considered.

Northern District Medical Society

A meeting of the Northern District Medical Society was held at Dauphin, on Wednesday, November 8th.

Present were: Doctors Wm. Bashucky, Winnipegosis; R. L. Gendreau, Ste. Rose du Lac; T. E. Kinash, Gilbert Plains; M. Cham, Benito; R. T. Watkins, McCreary; Ruth Fryer, Ethelbert; R. M. Creighton, R. E. Dicks, A. S. Little, M. Potoski, W. G. Ritchie and J. M. Woods of Dauphin; Eyjolfur Johnson, Selkirk; F. G. Allison, C. E. Corrigan, Cecil Harris, M. T. Macfarland and J. C. MacMaster of Winnipeg.

Dr. Eyjolfur Johnson, President of the Canadian Medical Association, Manitoba Division, brought greetings.

Following a delicious meal, which was served under the direction of the Lady Superintendent, Miss N. Negrich, a short business session was held in the Lecture Hall of the Health Unit.

The Chairman, Dr. R. E. Dicks, called for nominations for the new officers, and the following slate was unanimously approved:

President.....Dr. Adam S. Little, Dauphin
Vice-Pres.....Dr. R. L. Gendreau, St. Rose du Lac
Secretary.....Dr. W. G. Ritchie, Dauphin, and

Representative to Executive of the Canadian Medical Association, Manitoba Division.

At the scientific session, which was held in the Nurses' sitting room of the hospital, Dr. F. G. Allison of Winnipeg, spoke on "Progress in Cardiology" and Dr. C. E. Corrigan, on "Peripheral Vascular Surgery." Dr. Cecil Harris, Regional Director of the Red Cross Blood Transfusion Service, outlined a plan for establishing a Regional Depot at Dauphin. Dr. J. C. MacMaster discussed recent developments in connection with Manitoba Medical Service and Dr. M. T. Macfarland discussed the Manitoba Medical Service in relation to the Trans-Canada Medical Service Plan and the Sir Earle Page "New Conception of a National Health Scheme for Australia."

Medical Library Evening Hours

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The Library will be open from 8 p.m. to 10 p.m. Monday through Friday for four months, from December 1, 1950, to March 31, 1951, except for Christmas vacation period. Closed from December 20, 1950, to January 3, 1951 inclusive.

Regulations

(1) The Library Committee wishes it understood that the closing hour of 10 p.m. will be strictly adhered to.

(2) All reading room facilities will be available to physicians and students.

(3) The student on duty will assist in looking up subjects in the **quarterly cumulative index Medicus** for the last ten years.

(4) If previous references are required they should be obtained during the regular library hours (9 a.m. to 5.30 p.m.).

(5) The **Stackrooms** will not be open.

The Medical Library Committee.



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COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

Business Arising from Council Meeting May 23, 1950

(Continued from November issue)

N. Reciprocity With The Michigan State Board of Registration

The Registrar presented another communication from the Secretary of the Michigan State Board of Registration and Medicine, advising that the Michigan Board has agreed to advise and recommend to the Michigan Legislature that graduates of Class A Canadian Medical Schools be admitted to examination for registration and licensure in Michigan upon the same basis as the graduates of the two Michigan medical schools or any Class A United States Medical School who are citizens of Michigan or any of the other states. The proposed changes will probably be presented to a Joint Committee of the House and Senate's Rules and Regulations Committee for their approval, who will then present them to the Michigan Legislature at their next regular session, January 1, 1951, for their approval or disapproval.

Business Arising from Registration Committee Meetings

A. Temporary Licence for Locum Tenens

The question of temporary licences for Locum Tenens was discussed at the meeting of the Registration Committee held July 26, 1950, at which time it was recommended that the Council review the possibility of amending the by-laws to deal with matters concerning the licensing of qualified physicians for locum tenens. The opinion of the College solicitor was that the Council has authority to issue temporary licences and provide for the payment of fees therefor. Section 37 of the Medical Act reads: "Council shall from time to time as occasion may require make order, regulations or by-laws for regulating the Register kept under this Act and the fee to be paid for registration."

Motion: "THAT the Executive Committee recommend to Council that such a recommendation be adopted." Carried.

B. Student Registration

For information the Registrar advised that at the last two meetings of the Registration Committee one-half dozen students from other medical schools had been accepted for student registration with this College because their homes were in Manitoba, and their premedical standing was equivalent to that required by the University of Manitoba. In this year's class of first year medical

students at the University of Manitoba, there are students from Saskatchewan, Ontario and Alberta who applied for student registration with this College. Some are over 21 years of age and have taken their premedical training here. Ordinarily we accept only those who are resident in this Province.

Another point in connection with student registration is the case of a graduate from Laval University who comes to Manitoba and seeks registration with this College. He was refused student registration with this College in 1945 because his premedical training was not of the standing required by the University of Manitoba. He obtained his Enabling Certificate elsewhere, passed the examinations of the Medical Council of Canada, and we must now accept him for registration.

New Business

A. Request for Grant from Medical Library Committee

The Registrar presented a request from the Chairman of the Medical Library Committee, for the usual grant of \$750.00 from the College. This matter was referred to the Council.

B. Communication from International Refugee Organization

The Registrar reported he had a visit from Mr. Hector Allard, Chief of Mission (Canada) I.R.O., on August 22, 1950, at which time he went over the problem of registration of foreign graduates, and outlined the requirements laid down by the Council of the C.P. & S. of Manitoba. Upon his return to Hull, Quebec, Mr. Allard forwarded the following comment: "It was indeed very kind of you to receive me on Tuesday, August 22nd, to discuss points of mutual interest with regard to former Displaced Persons who have arrived in Canada and who claim to be members of the medical profession. After discussing this matter with you, I feel sure that D.P.'s are being given every possible consideration by the Manitoba College of Physicians and Surgeons, and this is due in great part to your keen interest in this problem."

It was agreed that this report should come to council since it clears up a point that has caused a great deal of misunderstanding, and that it be forwarded to the Manitoba Medical Association Committee on Public Relations.

Motion: "THAT a copy of the communication from the International Refugee Organization be forwarded to the Public Relations Committee of the Manitoba Medical Association, and that the

matter be brought to the attention of Council." Carried.

C. Re Basic Sciences Examinations

Communication from the Registrar, University of Manitoba, was presented, stating that two examination periods for the Basic Sciences examinations have been established, the first to be during the early part of April, and the second to be during the latter part of August, and that if a third period was found necessary it might be established. Regulations concerning the examinations were also enclosed.

D. Re Dr.

The Registrar reported that Dr. had been working at Hospital, and it was possible that an application for reinstatement might be forthcoming from him in time for the Council meeting. Dr. inquired whether he might be informed if such a request was made.

E. Request to Medical Arts Building for Parking Space

The Registrar reported he had made application to the Medical Arts Building for parking space for use of the Executive Officers of the College.

F. Appointment of Registrar, C. P. & S., B.C., To Replace Dr. A. J. MacLachlan, Deceased

The Registrar presented notice from the College of Physicians and Surgeons of British Columbia of the death of the Registrar of many years standing, Dr. MacLachlan, and of the appointment of Dr. Murray Blair. The Registrar reported he had sent condolences concerning the death of Dr. MacLachlan and congratulations to Dr. Blair on his appointment as Registrar.

G. Complaint from Mr.

The Registrar presented a lengthy letter of complaint which was referred by the Executive of the Manitoba Medical Association. Mr. objected to treatment received from two Winnipeg doctors, which he claims made him very much worse. The Registrar was requested to acknowledge receipt of the letter, stating that it has been considered and there is no action to be taken, and then file it.

H. Dr.

The Registrar reported that further word had been received from the Workmen's Compensation Board that several of Dr. 's reports were again outstanding. This matter was before the Discipline Committee and Council last year, and Dr. gave an undertaking at that time which appeared acceptable. The Committee suggested that the W.C.B. should be advised not to allow Dr. to do any work for them since

he is embarrassing the Board and the patients. The patients cannot receive any compensation until the doctor's reports are received.

Motion: "THAT the matter of Dr. 's outstanding reports to the Workmen's Compensation Board be referred to the Discipline Committee." Carried.

I. Special Congregation, University of British Columbia

For information, the Registrar reported an invitation had been received for the Special Congregation to mark the opening of the Faculty of Medicine, University of British Columbia, and celebrate the Golden Jubilee of the British Columbia Medical Association, September 27, 1950.

J. Date of Council Meeting

The Committee agreed that the Annual Council Meeting should be held at 2 o'clock p.m., on Wednesday, October 18th, 1950.

(To be Continued)

Post Graduate Lectures

on the Management of Various Common Disorders

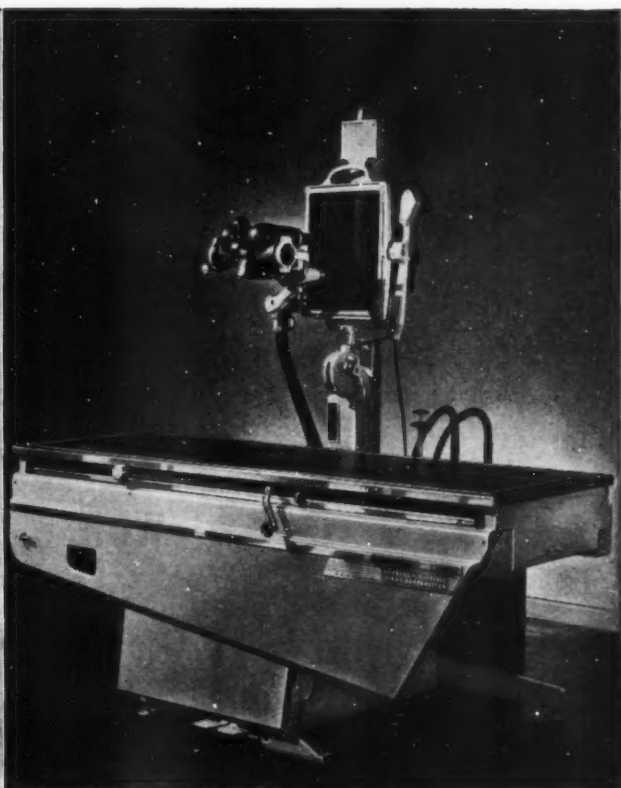
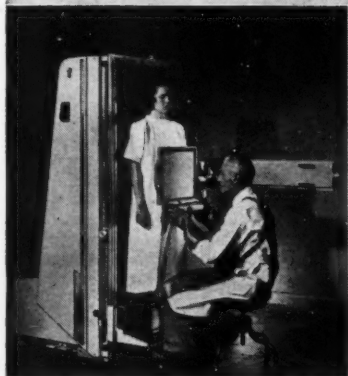
It is planned to hold a series of lectures during the winter of 1951 on the Management of Various Common Disorders.

The lectures will be held each Monday at 8 p.m. in the Pathology Lecture Theatre, commencing Jan. 8th.

The cost will be approximately \$15.00 for the series of lectures.

Will those interested please contact Dr. John Matas or Dr. J. Graham Pincock at Deer Lodge Hospital.

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Department of Health and Public Welfare
Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1950		1949		Total	
	Sept. 10 to Oct. 7, '50	Aug. 13 to Sept. 9, '50	Sept. 11 to Oct. 8, '49	Aug. 14 to Sept. 10, '49	Jan. 1 to Oct. 7, '50	Jan. 1 to Oct. 8, '49
Anterior Poliomyelitis	2	1	19	46	9	107
Chickenpox	64	50	42	18	1086	973
Diphtheria	2	8	0	1	15	16
Diarrhoea and Enteritis, under 1 yr.	16	14	40	40	106	261
Diphtheria Carriers	0	0	0	1	0	4
Dysentery—Amoebic	0	0	0	0	1	0
Dysentery—Bacillary	5	11	9	5	111	22
Erysipelas	11	1	1	2	44	22
Encephalitis	0	1	6	23	1	35
Influenza	14	9	11	7	136	204
Measles	32	23	94	55	1102	5088
Measles—German	0	0	1	4	31	100
Meningococcal Meningitis	0	0	3	2	11	23
Mumps	34	20	23	9	306	923
Ophthalmia Neonatorum	0	0	0	1	1	1
Pneumonia—Lobar	11	11	14	7	171	159
Puerperal Fever	0	1	1	0	4	5
Scarlet Fever	42	17	24	8	264	102
Septic Sore Throat	11	0	4	3	37	32
Smallpox	0	0	0	0	0	0
Tetanus	1	0	1	0	2	3
Trachoma	0	0	0	0	0	1
Tuberculosis	124	68	81	78	701	1021
Typhoid Fever	0	0	2	2	3	11
Typhoid Paratyphoid	0	0	0	0	0	1
Typhoid Carriers	0	0	0	1	2	4
Undulant Fever	1	1	3	4	25	18
Whooping Cough	63	65	6	8	243	159
Gonorrhoea	131	141	118	126	996	1102
Syphilis	13	8	33	22	183	329
Tularemia	0	0	0	0	5	0

	Oct. 8 to Nov. 4, '50	Sept. 10 to Oct. 7, '50	Oct. 9 to Nov. 5, '49	Sept. 11 to Oct. 8, '49	Jan. 1 to Nov. 4, '50	Jan. 1 to Nov. 5, '49
Anterior Poliomyelitis	4	2	9	19	13	116
Chickenpox	118	64	219	42	1204	1192
Diphtheria	1	2	0	0	16	16
Diarrhoea and Enteritis, under 1 yr.	12	16	15	40	118	276
Diphtheria Carriers	3	0	0	0	3	4
Dysentery—Amoebic	0	0	0	0	1	6
Dysentery—Bacillary	15	5	5	9	126	27
Erysipelas	1	11	5	1	45	27
Encephalitis	0	0	1	6	1	36
Influenza	13	14	7	11	149	211
Measles	84	32	323	94	1186	5411
Measles—German	2	0	5	1	33	105
Meningococcal Meningitis	1	0	3	3	12	26
Mumps	66	34	17	23	372	940
Ophthalmia Neonatorum	1	0	0	0	2	1
Pneumonia—Lobar	17	11	17	14	188	176
Puerperal Fever	0	0	0	1	4	5
Scarlet Fever	62	42	47	24	326	149
Septic Sore Throat	8	11	8	4	45	40
Smallpox	0	0	0	0	0	0
Tetanus	0	1	0	1	2	3
Trachoma	0	0	4	0	0	5
Tuberculosis	84	124	58	81	785	1079
Typhoid Fever	0	0	1	2	3	12
Typhoid Paratyphoid	0	0	0	0	0	1
Typhoid Carriers	0	0	0	0	2	4
Undulant Fever	2	1	5	3	27	23
Whooping Cough	57	63	7	6	300	166
Gonorrhoea	127	131	129	118	1123	1231
Syphilis	11	13	21	33	194	350
Tularemia	0	0	0	0	5	0

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Four-Week Period September 10th to October 7th, 1950

DISEASES (White Cases Only)	*779,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,982,000 Minnesota
*Approximate population.				
Anterior Poliomyelitis	2	43	107	144
Chickenpox	64	83	269	—
Diarrhoea and Enteritis	16	—	—	—
Diphtheria	2	2	4	11
Dysentery—Amoebic	—	—	—	4
Dysentery—Bacillary	5	—	33	39
Encephalitis Epidemica	—	6	—	—
Erysipelas	11	1	2	—
Infectious Jaundice	—	4	10	—
Influenza	14	—	11	8
Measles	32	27	424	24
Measles, German	—	17	161	—
Meningitis Meningococcal	—	2	4	5
Mumps	34	152	293	—
Pneumonia, Lobar	11	—	—	—
Parotid Fever	—	—	—	—
Scarlet Fever	42	38	75	18
Septic Sore Throat	11	1	4	14
Smallpox	—	—	—	—
Tetanus	1	—	—	—
Trachoma	—	—	1	—
Tuberculosis	124	45	130	231
Tularemia	—	—	—	—
Typhoid Fever	—	2	2	1
Typh. Para-Typhoid	—	—	2	—
Typhoid Carrier	—	—	—	—
Undulant Fever	1	—	3	15
Whooping Cough	63	13	440	79
Gonorrhoea	131	—	248	—
Syphilis	13	—	71	—

Four-Week Period October 7th to November 4th, 1950

Anterior Poliomyelitis	4	10	53	115
Chickenpox	118	313	865	—
Diarrhoea & Enteritis, under 1 yr.	12	—	—	—
Diphtheria	1	3	13	9
Diphtheria Carriers	3	—	—	—
Dysentery—Amoebic	—	—	—	1
Dysentery—Bacillary	15	—	32	5
Encephalitis Epidemica	—	—	—	2
Erysipelas	1	3	2	—
Influenza	13	—	22	2
Infectious Jaundice	—	—	2	—
Measles	84	89	1082	22
German Measles	2	37	196	—
Meningitis Meningococcal	1	—	12	1
Mumps	66	225	625	—
Ophthalmia Neonatorum	1	—	—	—
Pneumonia, Lobar	17	—	—	—
Parotid Fever	—	—	—	—
Scarlet Fever	62	47	141	36
Septic Sore Throat	8	5	8	35
Smallpox	—	—	—	—
Tetanus	—	—	—	—
Trachinosis	—	—	—	1
Trachoma	—	—	—	—
Tuberculosis	84	46	101	169
Typhoid Fever	—	—	3	—
Typh. Para-Typhoid	—	—	3	—
Typhoid Carrier	—	1	—	—
Undulant Fever	2	2	4	14
Whooping Cough	57	15	594	57
Gonorrhoea	127	—	290	—
Syphilis	11	—	76	—

DEATHS FROM REPORTABLE DISEASES

For the Month of October, 1950

Urban—Cancer, 53; Influenza, 1; Lethargic Encephalitis, 1; Pneumonia (other forms), 5; Poliomyelitis, 1; Syphilis, 1; Tuberculosis, 6; Gastro-Enteritis and Colitis, 1; Hodgkin's Disease, 1; Multiple Myeloma, 2; Leukemia and Aleukemia, 2. Other deaths under 1 year, 31. Other deaths over 1 year, 219. Stillbirths, 22. Total, 272.

Rural—Cancer, 36; Influenza, 4; Lethargic Encephalitis, 2; Measles, 1; Pneumonia (other forms), 7; Syphilis, 1; Tuberculosis, 6; Gastro-Enteritis and Colitis, 2; Multiple Myeloma, 1. Other deaths under 1 year, 9. Other deaths over 1 year, 163. Stillbirths, 17. Total, 189.

Islands—Influenza, 2; Pneumonia (other forms), 7; Poliomyelitis, 1; Tuberculosis, 2; Gastro-Enteritis and Colitis, 1. Other deaths under 1 year, 4. Other deaths over 1 year, 4. Stillbirths, 2. Total, 10.

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Names and Phone Numbers of

Detailmen

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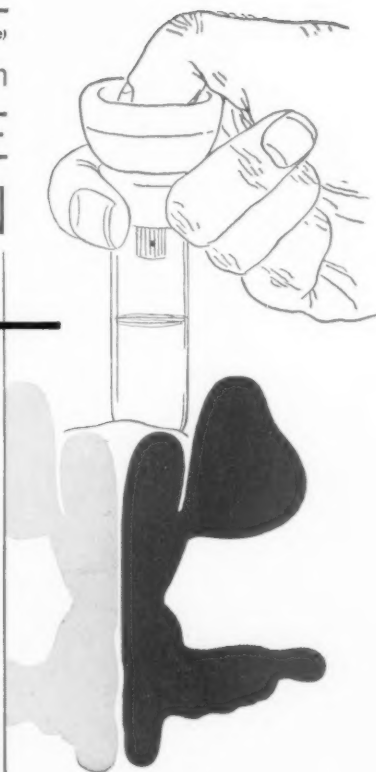
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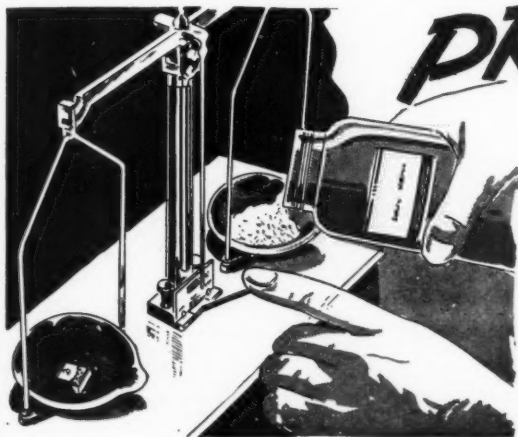
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